STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966476	**08/27/2015**
NAME OF PROVIDER OR SUPPLIER **CLARKE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **48 EMERSON DRIVE NW MELBOURNE, FL 32907**	

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

0000 Initial Comments

Complaint Investigation #2015005502) was conducted on . . Clarke's Assisted Living had deficiencies at the time of the visit.

0025 Resident Care - Supervision

Based on observation, record review and interview, the facility failed to ensure a proactive plan was in place to prevent severe weight loss, and failed to notify the healthcare provider and the responsible party of the weight changes for 6 of 9 sampled residents (#1, 2, 4, 5, 7 & 8).

Findings:

The Agency received information that indicated residents in the facility had experienced severe weight loss.

Review of the Resident Weight Records revealed the following:

1. Resident #1 had an Assisted Living Facility Health Assessment Form (1823) updated on .
The resident's admission weight was 145 pounds (lb.) on . . / .
Review of the Resident Weight Record revealed:
. . . / . = 226 lb.
. = 211 lb., a 15 lb. weigh loss in 6 months
. = 203 lb., an 8 lb. weight loss in 6 month
. = 170 lb., a 33 lb. weight loss in 6 months
. . . = 153.4 lb., a 16.6 lb. weight loss in 6 months
. / . = 129 lb., a 24.4 lb. weight loss in 6 months
There was a 41 lb weight loss in one year and 97 pound weight loss in 2 years.

On / at approximately 2 PM, the administrator stated she was going to ask the physician for a supplement for the resident.

2. Resident #8 had an 1823 form dated / that indicated a diagnosis of chronic .
The resident's admission weight was 190 lb. on .
Review of the resident weights revealed the following:
/ . = 182 lb.
. = 150 lb., a 32 lb. weight loss in a year
. = 134 lb., a 16 lb. weight loss a year; 48 lb. weight loss in 2 years

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= 123 lb., an 11 lb. weight loss in 7 months; 69 lb. weight loss in 3 years.

3. Resident #2 had an 1823 form dated that indicated a diagnosis of . The resident's admission weight was 95.2 lbs.
Review of the resident's weights revealed the following:
= 98.4 lb.
= 88.2 lb., a 10.2 lb. weight loss in one month.

4. Resident #4 had an 1823 form dated that indicated a diagnosis of .
The resident needed assistance with activities of daily living.
The resident's admission weight was 170 lb. on .
Review of the resident's weights revealed the following:
= 160 lb.
= 154 lb., a 6 lb. weight loss in 6 months
= 140 lb., a 14 lb. weight loss in 6 months, and 20 lb. in a year.

5. Resident #5 had an 1823 form dated that indicated a diagnosis of . The resident's admission weight was 160 lb. on .
Review of the resident's weights revealed the following:
= 165 lb.
= 154 lb., an 11 lb. weight loss in 5 months.

6. Resident #7 had an 1823 form dated that indicated a diagnosis of .
The resident's admission weight was 179 lb. on .
Review of the resident's weights revealed the following:
= 175 lb.
= 165.6 lb., a 9.4 lb. weight loss in 3 months.

Record review revealed there was not documentation that indicated the healthcare provider and responsible party were notified of the weight loss for residents #1, 2, 4, 5, 7 and 8.

In an interview on at approximately 11 AM, the FACT Registered Nurse stated the some of the residents' weights were dropping drastically but the weights were coming up now. She indicated that there was no medical condition which would cause the residents to lose weight. Most of the medications they were on caused weight gain. The administrator a few years ago and they thrived when he was here. I come every Monday to check their weights.

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966476	08/27/2015
NAME OF PROVIDER OR SUPPLIER **CLARKE'S ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **48 EMERSON DRIVE NW** **MELBOURNE, FL 32907**	

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

0093 Food Service - Dietary Standards

Based on record review and interview, the facility failed to ensure the emergency food supply contained the required amount of non-perishable milk.

Findings:

Review of the emergency food supply revealed the facility needed more non-perishable milk: 5 residents x 3 cups per day x 3 days = 11.5 quarts. The facility did not have any non-perishable milk on hand.

On at approximately 2:30 PM, the administrator stated she was not aware the facility needed more milk

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Clarke's Assisted Living
48 Emerson Drive Nw
Melbourne, FL 32907
Attention: Nichele Clarke

Dear Mrs. Clarke:

This letter reports the findings of a complaint inspection (CCR#2015005502) survey conducted on , by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) **by** .

The inspection resulted in findings of non-compliance in the following areas:

1) A - 0025 - Resident Care - Supervision Class II
Your facility Failed to ensure a proactive plan was in place to prevent severe weight loss and failed to notify the healthcare provider and the responsible party of their weight changes.

Directed Corrective Actions:

1. The facility need to have a policy on what steps need to be taken when a resident has weight loss. This policy needs to include but limited to notifying the physician immediately and documenting weights as instructed and what other dietary measures my be ordered. As part of Corrective action the above policy and review must be available for review by the Agency upon request **by** .

2. A log needs to be established, so that when the nurse from the FACT team comes in to weigh the residents every Monday you can compare the weight to the previous weeks and document if there are any concerns. If there are concerns the residents weight needs to be monitored immediately and subsequently the resident's physician and representative need to be notified. This must be put in place by .

3. The residents primary physicians must be contacted relating to their weight loss. The Fact Team is only there to monitor the residents use of medications and to assess the residents mental needs. This must be done immediately .

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Clarke's Assisted Living
[illegible], 2015

4. The facility staff need to be in-serviced immediately on the policy and procedures for weight loss. The in-service documentation and sign in sheet must be available for Agency review upon request. This must be completed by [illegible].

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Lorraine Henry, Health Facility Evaluator Supervisor, at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be

D7JR

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2015

Administrator
Clarke's Assisted Living
48 Emerson Drive NW
Melbourne, FL 32907

RE: CCR #2015005502

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office.

Attached 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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