STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968650	08/31/2015
NAME OF PROVIDER OR SUPPLIER **ENCLAVE ASSISTED LIVING II**	STREET ADDRESS, CITY, STATE, ZIP CODE **2518 BERNICE COURT** **MELBOURNE, FL 32935**	

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

0000 Initial Comments

A complaint investigation (CCR 2015007549) was held at the Enclave II Assisted Living Facility in Melbourne, Florida on / . The facility had deficient practice at the time of the investigation.

0010 Admissions - Continued Residency

Based on record review and interviews the facility failed to obtain an updated Agency for Health Care Administrator (AHCA) 1823 Health Assessment for 2 of 5 residents (Residents #2 and #3) based on significant behavioral and medical changes from their initial AHCA 1823 Health Assessment.
Findings:
1. On / / , a record review of Resident #2's AHCA 1823 Health Assessment indicated that Resident #2 was admitted to the facility on . At the time Resident #2 was admitted to the facility, Resident #2 had a diagnosis of , dependent and , . Resident #2's weight was 270 pounds on the day of admission.
On / / , in a record review of Resident #2's Medication Observation Record (MOR) it indicated that Resident #2 was not being prescribed .
On / / , in a record review of Resident #2 ' s file, it indicated that Resident #2's weight was at 282 pounds on .
On / / , in a continued record review of Resident #2's file, it indicated that Resident #2 had 10 incidents related to behavioral concerns. These included: / / - Resident #2 complaining that she is losing weight and does not get enough to eat, / / - Resident #2 left on her bike and returned with beer, / / - Resident #2 stayed up all night, cooking and preparing food at 2:00 AM, Resident #2 refused to stop cooking when directed by staff, / / - Resident #2 stayed up all night, leaving the facility late at night to try and find funnel cakes, / / - Resident #2 off of her bike and law enforcement was called to pick her up, / / - Resident #2 stayed up all night cooking and eating, / / - Resident #2 and required law enforcement to come and pick her up, - Resident #2 announced to all of the other residents that her goal was to make everyone else miserable, / / - Resident #2 left the facility riding her bike, while in the community she and law enforcement was called to come and pick her up, / - Resident #2 rode her bike to a local department store, and law enforcement had to come and pick her up.
On / / at 3:30 PM in an interview with the facility administrator, the facility administrator stated that Resident #2 was not prescribed with at the time of admission. The facility administrator provided copies of the hospital discharge which indicated that Resident #2 was not prescribed . When asked, the facility administrator acknowledged that she had not requested an undated AHCA 1823 Health Assessment to clarify the situation regarding the usage of .
On / / at 3:30 PM in a continued interview with the facility administrator, the facility administrator stated that she had not requested that Resident #2 be provided with an updated AHCA 1823 Health

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Assessment based on the behavioral changes and weight gain.
2. On /, a record review of Resident #3's AHCA 1823 Health Assessment indicated that Resident #3 was admitted to the facility with a diagnosis of dependence, gait imbalance, Parkinson's and uses a wheel chair. At the time of admission, Resident #3's weight was documented at 155 pounds.
On / /, a record review of Resident #3's file indicated that Resident #3 had significant weight gain while living at the facility. The facility documented that Resident #3 weighted 170 pounds on / and 180 pounds on .
On /, in a continued record review of Resident #3's file, it indicated that Resident #3 had 8 incidents of significant behavioral changes. The changes in Resident #3 behavior include the following: / - Resident #3 left the facility and was intoxicated when he returned, / - Resident #3 went on a drinking binge with a bottle of vodka, Resident #3 ended up at the local convenience store, the store contacted law enforcement who came and Resident #3, / - while intoxicated, Resident #3 out of his wheel chair, / - the facility staff cleaned Resident #3's discovered hidden bottles of beverages, Resident #3 spent the day intoxicated, / - Resident #3 spent the day at the facility intoxicated, - Resident #3 left the facility to attend his high school reunion, he did not return or make contact with the facility, / / - Resident #3 returned to the facility and was intoxicated, / - Resident #3 spent the day intoxicated, calling other residents names.
On /, at 3:30 PM, in an interview with the facility administrator, the facility administrator was asked when Resident #3 left the hospital from the if the facility had requested an updated AHCA 1823 Health Assessment and she stated "no". When the facility administrator asked about the significant medical change of 25 pounds and the behavioral changes had the facility requested an updated AHCA 1823 Health Assessment and the facility administrator stated, "No".
Class III

0025 Resident Care - Supervision

Based on record review and interviews the facility left residents at risk of harm by failing to report significant behavioral and medical changes in 2 of 5 residents (Resident #2 and #3) to the resident's health care provider or other appropriate party.
Findings include;
On / /, a record review was conducted of Resident #2's file which indicated that Resident #2 was admitted to the facility on /. At the time Resident #2 was admitted to the facility, Resident #2's weight was 270 pounds. On /, the last posting of weight checks for Resident #2, it was documented that Resident #2's weight was 282 pounds.
On / /, in a continued record review of Resident #2's file, it indicated that Resident #2 had 10 incidents related to behavioral concerns. These included: / - Resident #2 complaining that she is losing weight and does not get enough to eat, / - Resident #2 left on her bike and returned with

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beer, [illegible] - Resident #2 stayed up all night, cooking and preparing food at 2:00 AM, Resident #2 refused to stop cooking when directed by staff, [illegible] - Resident #2 stayed up all night, leaving the facility late at night to try and find funnel cakes, [illegible] - Resident #2 [illegible] off of her bike and law enforcement was called to pick her up, [illegible] - Resident #2 stayed up all night cooking and eating, [illegible] - Resident #2 [illegible] and required law enforcement to come and pick her up, [illegible] - Resident #2 announced to all of the other residents that her goal was to make everyone else miserable, [illegible] - Resident #2 left the facility riding her bike, while in the community she [illegible] and law enforcement was called to come and pick her up, [illegible] - Resident #2 rode her bike to a local department store, [illegible] and law enforcement had to come and pick her up.

On [illegible] at 3:30 PM in an interview with the facility administrator, the facility administrator stated when asked if she had made attempts to contact the family, case manager or health care provider for Resident #2, she stated, "No" to any attempt being made.

2. On [illegible], a record review was conducted of Resident #3's file which indicated that Resident #3 was admitted to the facility on [illegible]. At the time Resident #3 was admitted to the facility, Resident #3's weight was 155 pounds. On [illegible], the last posting of weight checks for Resident #3, it was documented that Resident #3's weight was 180 pounds.

On [illegible], in a continued record review of Resident #3's file, it indicated that Resident #3 had 8 incidents of significant behavioral changes. The changes in Resident #3 behavior include the following: [illegible] - Resident #3 left the facility and was intoxicated when he returned, [illegible] - Resident #3 went on a drinking binge with a bottle of vodka, Resident #3 ended up at the local convenience store, the store contacted law enforcement who came and [illegible] Resident #3, [illegible] - while intoxicated, Resident #3 [illegible] out of his wheel chair, [illegible] - the facility staff cleaned Resident #3's [illegible] discovered hidden bottles of [illegible] beverages, Resident #3 spent the day intoxicated, [illegible] - Resident #3 spent the day at the facility intoxicated, [illegible] - Resident #3 left the facility to attend his high school reunion, he did not return or make contact with the facility, [illegible] - Resident #3 returned to the facility and was intoxicated, [illegible] - Resident #3 spent the day intoxicated, calling other residents names.

On [illegible] at 3:30 PM, in an interview with the facility administrator, the facility administrator stated when asked if she had contacted the family members or health care provider for Resident #3 to report the change in significant behavior. The facility administrator stated "No" to making family or health care provider contact.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Enclave Assisted Living II
2518 Bernice Court
Melbourne, FL 32935

RE: CCR #2015007549

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation 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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