STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964072	03/24/2016
NAME OF PROVIDER OR SUPPLIER **BROOKDALE WEST MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7300 GREENBORO DRIVE** **MELBOURNE, FL 32904**	

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

0000 Initial Comments

Limited Nursing Services monitoring was conducted on . Brookdale West Melbourne had a deficiency at the time of the visit.

0079 Staffing Standards - Levels

Based on record review and interview the facility did not make sure that a staff member who had completed courses in First Aid and ( ) and held a currently valid card documenting completion of such courses was in the facility at all times when the residents were present.
Findings:
Staff schedule review revealed staff A and D were scheduled to work from 10 PM to 6 AM on .
The 2 staff also worked together on and / .
Personnel record review for staff #A revealed no evidence she completed courses on and First Aid.
Personnel record for staff D revealed she had certification that expired . There was no evidence to confirm she had First Aid certification.
In an interview with the administrator on at approximately 4 PM who stated changes had been made in the business office and the certification was overlooked.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Brookdale West Melbourne
7300 Greenboro Drive
Melbourne, FL 32904

RE: LNS monitoring

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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 , 2016.** 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

XG90

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