STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965814	03/02/2017
NAME OF PROVIDER OR SUPPLIER **BROOKDALE BECKETT LAKE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2155 MONTCLAIR ROAD** **CLEARWATER, FL 33763**	

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

0000 - Initial Comments

Assisted Living Facility

Two complaint investigations, (CCR# 2017000194 & CCR# 2017000286), were conducted at Brookdale Beckett Lake, (Lic. #10143), on . Brookdale Beckett Lake, Assisted Living Facility, had a deficiency at the time of the investigations.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview, the facility had not contacted the resident's family, guardian or health care surrogate when a resident exhibited a significant change, moved out or was discharged with respect to three of three (#1; 2; 3) residents sampled.

Findings included:

A review of resident files during the investigation found a progress note from indicating that Resident #1 (admitted) "had discoloration to the L eye and a to the L side of the forehead." Further review of this entry revealed no documented evidence that the surrogate, guardian or family member/representative had been notified by the facility regarding this sudden change in appearance. In addition, a progress entry from stated that the resident "had been sent out to the local hospital due to not being able to walk." Although interview with facility administration at 1:15pm on verified that the resident's family member was aware of this hospitalization, they concurred that no written proof had been furnished in the record.

Review of Resident #2's record indicated that this individual (admitted) had experienced a and L ischeal in , 2016. Further review of the file found no corresponding incident report or adverse incident report. Per the administrator, district director of clinical services and district director of operations at 1:40pm on , they stated that "this event had occurred during the watch of the previous ownership/administration, and that no subsequent episode of this nature had occurred/not been reported to the Agency. However, the event had no documentation that any attempt to contact one of the resident's family members had been done. This also was the case regarding the resident's most recent /slip off of the bed on . Again, no verification that family had been notified or a message left had been entered in the record.

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Finally, with respect to Resident #3 (admitted), this individual per a progress note was "sent out to the hospital via the emergency or about due to pain, sweating and ." Further review of the file found no evidence that a family member/emergency contact had been notified regarding this action.

Interview with the administrator, district director of clinical services and district director of operations at 2:30pm on confirmed the lack of family/representative contact or documentation thereof with respect to significant changes, potentially significant changes in the resident's clinical status, or when the resident moved/was sent out of the facility regarding Residents #1-3.

Class III