STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965424	04/07/2017
NAME OF PROVIDER OR SUPPLIER **BROOKDALE LAKE ORIENTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **217 BOSTON AVENUE** **ALTAMONTE SPRINGS, FL 32701**	

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

0000 - Initial Comments

Complaint Investigation #2017000100 was conducted on , , and in conjunction with a Relicensure survey. Brookdale Lake Orienta, License #9795, had deficiencies at the time of the visit.

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

Based on observation, interview and record review, the facility was not aware that 1 of 10 sampled residents had developed a , , did not have any interventions in place to prevent further which resulted in the pressure becoming unstageable, did not maintain a written record of a significant change, and did not contact the family and health care provider for the , , which resulted in medical attention and additional medical services (#2).

Findings:

Resident #2's record revealed a Health Assessment Form 1823 dated that included diagnoses of , , and Parkinson . He required total care with ambulation, transfers and toileting. Review of the home health notes revealed that on , the nurse documented he had a , that measured 2.6 centimeters (cm.) by 1 cm. by 0.01 cm. on , and measured 2.4 cm. by 2.3 cm. by 0.1 cm. on . The record did not reveal any facility documentation that the resident had a , when it was first observed as a , and that the family and health care provider were notified.

On at 2 PM, the health and wellness director confirmed there were no facility notes. She said she thought Resident #2 had an in the area and was not aware that the resident had a , .

On at 12:30 PM, resident #2's home health nurse found the resident in bed, lying partially on his left side. Caregiver K was also present. The home health nurse explained the care to the resident. She said the resident needed to be repositioned in bed in order for the nurse to be able to clean the thoroughly. Resident #2 asked caregiver K to move his right leg because he was unable to do so independently. The home health nurse said that the last notes on indicated a , on the / , area. After she removed the dressing and cleaned the . She said she would identify the , as unstageable because of the gray color at the center and the increased redness around the edges. She measured the entire reddened area as 4.8 cm. by 2.2 cm. She asked resident #2 if the area was painful, and he replied he really did not have much sensation in the area. She informed resident #2 that he needed new orders, and possibly

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needed to see a care , ... The resident did not voice any concerns regarding the increase size of his . . . . . She applied a Duo-Derm dressing to the area and said she would contact her office to proceed with the care. Resident #2 had a regular mattress and a cushion on his wheel chair. Caregiver K was asked if resident #2 could transfer, and she responded that in all the time she had been there, she had never seen the resident transfer.

On at 12:45 PM, resident #2 stated he wished to stay sitting on the bed, because he was going to watch TV. He was able to reposition in bed as long as he was on his side but was not able to move if he was on his back. He said when he sat in his wheelchair, he was able to use his arms to left himself up and rest his . . . . . a bit.

On at 2:30 PM, the Health and Wellness Director was asked what care and interventions the facility provided to help the resident relieve the pressure. She responded, "I'm not sure. I have to talk to home health." She said the resident was alert and mobile, and it was a challenge to get him to rest and relieve pressure to the area.

There was no documentation found to confirm that the facility had discussed the care of the resident #2's , ... with the home health agency to prevent further . . . . . The Health and Wellness Nurses were not aware that resident #2 was being treated for a , in order to provide him the care and service that he required from the facility staff.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and interview, the facility failed to treat 8 of 24 sampled residents with consideration, personal dignity, failed to respect resident rights with a clean and decent living environment (#1, 2, 9, 12, 14, 19, 22 & 23), and failed to answer call lights in a timely manner for 4 of 24 sampled residents (#11, 15, 16 & 17).

Findings:

1. On at 2:40 PM, resident #1's carpet stains in front of the bed, a black-brown like substance on the shower stall ceiling, and a large hole on the . . . . . baseboard wall near the shower. The Health and Wellness Director was present during this observation. At 2:50 PM, resident #1 said, "The stain up there has been there for 5 years." On . . . . . at 1 PM, the Maintenance Director confirmed the finding and stated he told management that resident #1 had a stain on the shower ceiling, and the resident would need to be out of the . . . . . he could work on the ceiling.

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2. On ..... at 10 AM, a foul musty odor came from resident #12's ..... . At 10:05 AM, the Health and Wellness Coordinator said resident #12 flooded his , flushing a diaper down the toilet 3 days ago on Monday night, ...

3. On ..... at 4:30 PM, resident #19's ..... carpet stains throughout the whole apartment.

On ..... at 1 PM, the Maintenance Director stated he was backlogged and running behind with cleaning the carpets in residents' units.

4. On at 2 PM, resident #22's carpet stains and clutter throughout the whole apartment.

On ..... at 1 PM, the Maintenance Director stated carpet staining is an ongoing issue, and the carpets have been cleaned multiple times in the past couple of months.

5. On at 12:30 PM, resident #2's dirty carpet and many large dark spots, especially by the resident's bed. At 2:30 PM, the Health and Wellness Director said she was aware the carpet was dirty.

6. Observation of the facility's call log system computer on at 11 AM with the Administrator revealed that residents #11, #15, #16 and #17 waited a very long time after pushing the call pendent for assistance. The breakdown wait times were:
#11 pushed at 7:53 AM, staff answered/assisted 11:31 AM - total wait time 3 hours 48 minutes
#15 pushed at 8:42 AM, staff answered/assisted 10:21 AM - total wait time 1 hour 49 minutes
#16 pushed at 9:43 AM, staff answered/assisted 10:42 AM - total wait time 59 minutes
#17 pushed at 9:47 AM, staff answered/assisted 10:42 AM - total wait time 55 minutes

Observation verified caregiver A's pager on at 11:50 AM was not working, and observation verified caregiver K's pager on ..... at 2:40 PM was not working.

On ..... at 3:40 PM, caregiver B confirmed that all the pagers were not working except hers. Caregiver B also stated there are a total of 4 total pagers in the office, and she replaced her pager with a new battery.

Observation of caregiver K's pager on ..... at 2:30 PM verified it still was not working.

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On at 3 PM, the Administrator showed three new pagers he had ordered on Monday, .

7. On at 11:20 AM, resident #14's apartment revealed clothing and other items in the shower stall.
The resident stated that she has not had hot water in her shower since she moved in on .
Resident #14 said she brought it to the attention of the administrator right away. She said Maintenance staff H told her it was because she was "at the end of the line" and she had to wait longer for the water to get there. She does have hot water in the kitchen sinks. She said her neighbors, farther from the source, do not have any issues with hot water in their apartments. She said the administrator told her a couple of weeks ago they had identified the problem. She has not heard from anyone since. She is tired of trying to bathe with the water from the and wants to take a shower. She said she doesn't feel as clean taking sponge baths. She said keeps other items in the stall because it is "useless as a shower right now". She said she does not feel as though anyone is taking her seriously.

Review of the maintenance record for through 2017, found work order requests for resident #14's hot water on , (no hot water for 3 weeks), , , and .
No comments were listed to indicate the status of the repair.

On at 12:45 PM, maintenance staff H said an outside plumbing company is addressing the hot water. He also said he had tested the water in resident #14's apartment and it was 108 degrees, and said she had to wait for the hot water to get to her .

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on review of staff schedules, time sheets and interview, the facility failed maintain accurate staff work schedules for hours worked.

Findings:

Review of the staff schedules and time sheets provided by the facility revealed the staff schedules were not accurate

Staff A - the schedule noted she worked on and from 7 AM-3 PM. The time she noted on she did not clock in, and she left at 1:57 on .

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Staff B - the schedule noted she worked on , , and from 3-11 PM. On , she was scheduled to work from 7 AM-3 PM. The time sheet noted that on she did not clock in, left work at 9:38 PM on , left at 1 PM on , and left at 9 PM on .

Staff C - the schedule noted she worked on from 11 PM-7 AM. The time sheet noted she did not clock in.

Staff J - the schedule noted she worked on from 7 AM-3 PM in the memory care unit. The time sheet noted she did not clock in.

Staff L - the schedule noted she worked on and from 7 AM-3 PM, and from 7 AM-11 PM. The time sheet noted she did not arrive on until 7:34 AM, and on at 8:17 AM. On , she left at 2 PM.

Staff M - the schedule noted she worked on and from 11 PM to 7 AM on both days. The time sheet noted she left at 6:07 AM on , and at 6 AM on .

Staff N - the schedule noted she worked on and from 7 AM-3 PM both days. The time sheet noted she did not clock in. On , the schedule noted she worked from 7 AM-3 PM. The time sheet noted she left at 2 PM.

Staff O - the schedule noted she worked on , , and . The time sheet noted she did not clock in on those days.

Staff P - the schedule noted she worked on from 11 PM-7 AM. The time sheet noted she left at 5:17 AM.

Staff Q - the schedule noted she worked on from 3-11 PM. The time sheet noted she left at 9 PM.

Staff R - the schedule noted she worked from 7 AM-3 PM. The time sheet noted she did not clock in.

On at 2:30 PM, the Health and Wellness director reviewed the schedules and timesheets and said staff L, a medication technician, would make the schedules, and she was off for the day, . She confirmed some of the dates on the schedule was not accurate.

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Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a safe living environment, free of hazards, and failed to ensure that all existing mechanical systems (hot water) were in good working order for 8 of 24 sampled residents (#1, 2, 9, 12, 14, 19, 22 & 23).

Findings:

1. On at 2:40 PM, resident #1's carpet stains in front of the bed, black-brown-like substance on the shower stall ceiling, and a large hole on the baseboard wall near the shower. The Health and Wellness Director was present during this observation.

On at 2:50 PM, resident #1 commented, "The stain up there has been there for 5 years."

On at 1 PM, the Maintenance Director confirmed the finding and stated he told management that resident #1 had a stain on the shower ceiling and the resident would need to be out of the he can touch.

2. On at 10 AM, a foul musty odor came from resident #12's . At 10:05 AM, the Health and Wellness Coordinator said resident #12 flooded his , flushing a diaper down the toilet 3 days ago on Monday night, . At 10:10 AM, the Maintenance Director confirmed the finding.

3. On at 4:30 PM, resident #19's carpet stains throughout the whole apartment.

On at 1 PM, the Maintenance Director stated he was backlogged and running behind with cleaning the carpets in residents' units.

4. On at 2 PM, resident #22's carpet stains and clutter throughout the whole apartment.

On at 1 PM, the Maintenance Director stated the staining of the carpet is an ongoing issue and the facility has cleaned the carpet multiple times in the past couple of months.

5. Observation of resident #14's apartment revealed she did not have a closet door in her . She also had clothing and other items in the shower stall.

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On at 11:20 AM, resident #14 stated that she has not had a closet door or hot water in her shower since she moved in on . Resident #14 said she brought it to the attention of the administrator right away. Maintenance staff H told her it was because she was "at the end of the line" and she had to wait longer for the water to get there. She said she does have hot water in the kitchen sinks. She said her neighbors, farther from the source, do not have any issues with hot water in their apartments. She said the administrator told her a couple of weeks ago that they had identified the problem. She has not heard from anyone since. She said she is tired of trying to bathe with the water from the and wants to take a shower. She said she doesn't feel as clean taking sponge baths.

Review of the maintenance record for , through 2017, found work order requests for Resident #14's hot water on , (no hot water for 3 weeks), , , and . No comments were listed to indicate what the status of the repair was. Also on the maintenance log were closet door work order requests dated , , , , and . The entry for reflected that a door was on order. Resident #14 said she complained several times, but still did not have a door.

On at 12:45 PM, maintenance staff H said the door has been on order and there is an outside plumbing company addressing the hot water. He also said he had tested the water in resident #14's apartment and it was 108 degrees, and that she had to wait for the hot water to get to her .

On at 9:45 AM, the administrator said he called in an outside plumber. He provided a business card and a statement dated from the plumber which stated they would replace the shower valve on . He said he told resident #14 the parts were on order.

6. On at 12:30 PM, resident #2's carpet in the dirty, and had many large dark spots, especially by the resident's bed. At 2:30 PM, the Health and Wellness Director said that she was aware the carpet was dirty.

Class III