STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964750	**05/12/2017**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE SPRING HILL**	STREET ADDRESS, CITY, STATE, ZIP CODE **10440 PALMGREN LN** **SPRING HILL, FL 34606**	

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

0000 - Initial Comments

On , an unannounced complaint investigation, CCR#2017005031, was conducted at Brookdale Spring Hill Assisted Living Facility located in Spring Hill, FL. (License #9255). Discernable deficiencies were identified as a result of this survey. The facility was not in compliance at this time.

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

Based on interview and record review, the facility failed to update a written record as it related to significant change in behavior for 1 of 10 sampled residents (Resident #4).

Findings:

During interview on at 11:45 AM, Employee J stated that she had worked at the facility for 5 months. Employee J stated that on the night of the incident with resident #4, the resident was yelling and cursing during 2:00 AM rounds. Employee J stated that when they checked on her she said nothing was wrong. She stated that as staff bent over to pick up trash from the floor, resident knocked the trash from her hand and tried to slap Employee C. Employee J stated that at that time Employee C blocked Resident #4 to protect her face. Resident #4 continued hitting attempts and Employee C slowly lowered resident to the floor to prevent harm to self and staff. Employee C was observed holding resident arm for approximately 2-3 minutes until calm. Employee J stated that when Employee C released resident's arms she began throwing trash over the . Employee J stated that no injury was observed after resident was assisted up from the floor. Employee J stated they exited the call the Director following the chain of command to report the incident and for further advise/actions to take. Employee J indicated that the director advised them to return to Resident #4's about 20 minutes to see if she was acting out and if so to send her out to the hospital for an evaluation. Employee J stated that upon return to Resident #4's was standing up in front of her mirror putting on makeup. Employee J stated that at this time she observed a small spot of on her arm. Employee J stated that Resident #4 noticed it as well and stated that it okay, she is a nurse and will clean it up. Employee J stated that resident was observed to be calm, , and interacting well with staff so we did not call the director back or notify 911. Additionally, Employee J stated that they did not call 911 because the director said not to at that time, if still agitated to send her out, but she was okay and calm. She states that Resident #4 is on psych medications and had been refusing meds for the past few days. Employee J stated that the chain of command is to notify the Med Tech, then the health and wellness director (who was off that night), the director, complete incident report, family contact and fax to the doctor. Employee J stated that they did everything the director advised them to do and that she has not had any training on dealing with combative residents that she can remember.

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On at 12:04 PM, review of Resident #4's incident report dated at 2:00 AM, indicated that resident had no apparent injury and the section labeled body parts involved was observed to be left blank.

On at 2:00 PM, an interview conducted with the Executive Director who stated that he did not contact Emergency Medical Service ( ) or the Department of Children and Families (DCF) because Employee C did not indicate that resident #4 obtained an injury to her right arm during the incident, therefore it was not necessary to contact those agencies. The Executive Director stated that the staff informed him that no injury occurred during the incident.

On at 2:15 PM, review of Resident #4's progress note from the Advanced Registered Nurse Practitioner (ARNP), dated , revealed that "Today staff reports more frequent episodes of aggression, threatening staff, was attempting to strike and was blocked by staff member causing a to right arm, often refusing medications again. Resident does have an appointment with the VA in Brooksville for follow-up on . Patient is agitated and resistive to ROS, she did walk out of interview and was angry." Documented under the Examination section skin indicated that: No or concerning , warm and dry, has purple , right with small , no . Under Assessments indicate: of right , of without complication, right, initial encounter. Treatment: of right , monitor with no treatment indicated; of without complication, right, initial encounter, monitor with no treatment needed.

On at 2:30 PM, review of resident log revealed no documentation related to the incident that occurred on involving Resident #4. A note dated at 9:30 PM, indicated that resident continues to refuse PM medications, was able to participate in dinner at 5:00 PM with no behavior issues noted.

On at 2:35 PM, review of resident log revealed a note dated at 2:30 PM, indicated that the facility notified Resident #4's sister of an incident that occurred on , , 2017.

Class III

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

Based on interview and record review, the facility failed to provide a safe a decent living environment, free from and neglect, for 1 of 10 residents (Resident #4), who suffered and to her right during an incident when staff were trying to restrain her arms.

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Findings:

During interview on at 11:45 AM, Employee J stated that she had worked at the facility for 5 months. Employee J stated that on the night of the incident with resident #4, the resident was yelling and cursing during 2:00 AM rounds. Employee J stated that when they checked on her she said nothing was wrong. She stated that as staff bent over to pick up trash from the floor, resident knocked the trash from her hand and tried to slap Employee C. Employee J stated that at that time Employee C blocked Resident #4 to protect her face. Resident #4 continued hitting attempts and Employee C slowly lowered resident to the floor to prevent harm to self and staff. Employee C was observed holding resident arm for approximately 2-3 minutes until calm. Employee J stated that when Employee C released resident's arms she began throwing trash over the . Employee J stated that no injury was observed after resident was assisted up from the floor. Employee J stated they exited the call the Director following the chain of command to report the incident and for further advise/actions to take. Employee J indicated that the director advised them to return to Resident #4's about 20 minutes to see if she was acting out and if so to send her out to the hospital for an evaluation. Employee J stated that upon return to Resident #4's was standing up in front of her mirror putting on makeup. Employee J stated that at this time she observed a small spot of on her arm. Employee J stated that Resident #4 noticed it as well and stated that it okay, she is a nurse and will clean it up. Employee J stated that resident was observed to be calm, , and interacting well with staff so we did not call the director back or notify 911. Additionally, Employee J stated that they did not call 911 because the director said not to at that time, if still agitated to send her out, but she was okay and calm. She states that Resident #4 is on psych medications and had been refusing meds for the past few days. Employee J stated that the chain of command is to notify the Med Tech, then the health and wellness director (who was off that night), the director, complete incident report, family contact and fax to the doctor. Employee J stated that they did everything the director advised them to do and that she has not had any training on dealing with combative residents that she can remember.

On at 2:15 PM, review of Resident #4's progress note from the Advanced Registered Nurse Practitioner (ARNP), dated , revealed that "Today staff reports more frequent episodes of aggression, threatening staff, was attempting to strike and was blocked by staff member causing a to right arm, often refusing medications again. Resident does have an appointment with the VA in Brooksville for follow-up on . Patient is agitated and resistive to ROS, she did walk out of interview and was angry." Documented under the Examination section skin indicated that: No or concerning , warm and dry, has purple right with small , no . Under Assessments indicate: of right , of without complication, right, initial encounter. Treatment: of right , monitor with no treatment indicated; of without complication, right, initial encounter, monitor with no treatment needed.

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Class II

0080 - Training - Core & Competency Test - 429.52(1-2) FS; 58A-5.0191(1) FAC

Based on interview and record review, the facility failed to train staff on how to deal with combative residents for 40 of 40 residents of the facility.

Findings:

During an interview on at 9:37 AM, Employee A stated that she had worked at the facility for 17 years and received training related to ongoing. She stated that she had been taught to report suspected to the facility nurse. She described , as hitting. She described as talking to the residents in a rude tone. She stated that she had been taught to look for help in response to a resident experiencing a catastrophic reaction. Employee A stated that she received a full -training course in , and during each monthly meeting, some training components are discussed as well. Employee A stated that she believes that she may have had some type of training on dealing with combative residents.

During an interview on at 11:20 AM, Employee M stated that he had worked at the facility for 4 years. He stated that he had received training related to through packets, paperwork and videos, but does not remember any training on dealing with combative residents. He stated that if he witnessed or suspected he would go straight to a manager. He described , as slapping, smacking and rough grabbing. He described as insulting, negative comments or talking about the resident as though they were not present. He stated that he had been taught to give the resident some space, try to find out what was disturbing the resident, get a nurse and assist the resident to some place quiet in response to a resident experiencing a catastrophic reaction.

During interview on at 11:45 AM, Employee J stated that she had worked at the facility for 5 months. She stated that she had received training related to on the computer and through 4 group trainings meetings. She described , as and . She described as fear and agitation. She stated she would report suspected to her , or call the 1-800 number. She stated the she had been taught to get someone to help him, help the resident to calm down and redirect the resident in response to a resident experiencing a catastrophic reaction. Employee J stated that on the night of the incident with Resident #4, the resident was yelling and cursing during 2:00 AM rounds. Employee J stated that when they checked on her she said nothing was wrong. She stated that as staff bent over to pick up trash from the floor, resident knocked the trash from her

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hand and tried to slap Employee C. Employee J stated that at that time Employee C blocked Resident #4 to protect her face. Resident #4 continued hitting attempts and Employee C slowly lowered resident to the floor to prevent harm to self and staff. Employee C was observed holding resident arm for approximately 2-3 minutes until calm. Employee J stated that when Employee C released resident's arms she began throwing trash over the . Employee J stated that no injury was observed after resident was assisted up from the floor. Employee J stated they exited the call the Director following the chain of command to report the incident and for further advise/actions to take. Employee J indicated that the director advised them to return to Resident #4's about 20 minutes to see if she was acting out and if so to send her out to the hospital for an evaluation. Employee J stated that upon return to Resident #4's was standing up in front of her mirror putting on makeup. Employee J stated that at this time she observed a small spot of on her arm. Employee J stated that Resident #4 noticed it as well and stated that it okay, she is a nurse and will clean it up. Employee J stated that resident was observed to be calm, , and interacting well with staff so we did not call the director back or notify 911. Additionally, Employee J stated that they did not call 911 because the director said not to at that time, if still agitated to send her out, but she was okay and calm. She states that Resident #4 is on psych medications and had been refusing meds for the past few days. Employee J stated that the chain of command is to notify the Med Tech, then the health and wellness director (who was off that night), the director, complete incident report, family contact and fax to the doctor. Employee J stated that they did everything the director advised them to do and that she has not had any training on dealing with combative residents that she can remember.

During an interview on at 12:15 PM, Employee F stated that he had worked at the facility for 4 months. He stated that he had received training related to through initial orientation, videos and monthly meetings. He described , as hitting, pushing forcing a resident to do something they did not want to. He described as yelling at a resident or making threats. He stated the he would report suspected to management. He stated that he would intervene if he actually witnessed . He stated that he had been taught to walk away, give the resident a couple of minutes to calm down and ask someone else to assist to redirect the resident in response to a resident experiencing a catastrophic reaction. Employee F stated that he had not received any training on dealing with combative residents as of yet.

During an interview on at 1:00 PM, Employee N stated that she had worked at the facility for 2 months and received training related to upon hire and ongoing during monthly meetings. She stated that she had been taught to report suspected to the facility nurse and management. She described , as hitting. She described as talking to the residents in a very bad tone of voice or cursing at them. She stated that she had been taught to look for help in response to a resident experiencing a catastrophic reaction. Employee N stated that she has not received any training

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on how to deal with combative residents.

During an interview on at 1:15 PM, Employee D stated that she had worked at the facility for 3 years and received training related to ongoing. She stated that she had been taught to report suspected to the facility management or the nurse. She described as any unwanted touch to the body like punching and hitting. She described as emotional yelling at someone. She stated that she has been taught to look for help in response to a resident experiencing a catastrophic reaction. Additionally, she indicated that she has not received training related to dealing with combative residents.

During an interview on at 1:30 PM, Employee H stated that she had worked at the facility for 1 year and received training related to /neglect upon hire then monthly during staff meetings. She is uncertain about receiving any training related to dealing with combative residents. She stated that she had been taught to report suspected to the facility management. She described as touch. She described as negative comments. She stated that she had been taught to look for help in response to a resident experiencing a catastrophic reaction.

On at 2:50 PM, during an interview conducted with the Health and Wellness Director revealed that there was no policy or training conducted on how to deal with resident exhibiting combative behaviors. The Health and Wellness director stated that staff were provided with learning objective modules related to Behavioral Expressions.
On at 3:00 PM, record review of training module #9 titled Behavioral Expressions indicated: Fatigue/Sun downing: Yelling, resisting ADL's, repetitive speech, wandering, exit seeking, rummaging, hitting, and shouting/yelling. Do not wake residents who are sleeping soundly. If your care routine involves waking people up in the morning to get them ready, discuss this with your supervisor. If your residents doze off in the afternoon, talk about scheduling a rest time for them instead of having them doze in common areas. When residents are up at night and restless, run programming with them: reminisce, sing, do snacktivities, or socialize.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to report an incident to the Department of Children and Families (DCF) for 1 of 10 residents (Resident #4), who suffered and to her right during an incident when staff were trying to restrain her arms.

Findings:

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During interview on at 11:45 AM, Employee J stated that she had worked at the facility for 5 months. Employee J stated that on the night of the incident with resident #4, the resident was yelling and cursing during 2:00 AM rounds. Employee J stated that when they checked on her she said nothing was wrong. She stated that as staff bent over to pick up trash from the floor, resident knocked the trash from her hand and tried to slap Employee C. Employee J stated that at that time Employee C blocked Resident #4 to protect her face. Resident #4 continued hitting attempts and Employee C slowly lowered resident to the floor to prevent harm to self and staff. Employee C was observed holding resident arm for approximately 2-3 minutes until calm. Employee J stated that when Employee C released resident's arms she began throwing trash over the . Employee J stated that no injury was observed after resident was assisted up from the floor. Employee J stated they exited the call the Director following the chain of command to report the incident and for further advise/actions to take. Employee J indicated that the director advised them to return to Resident #4's about 20 minutes to see if she was acting out and if so to send her out to the hospital for an evaluation. Employee J stated that upon return to Resident #4's was standing up in front of her mirror putting on makeup. Employee J stated that at this time she observed a small spot of on her arm. Employee J stated that Resident #4 noticed it as well and stated that it okay, she is a nurse and will clean it up. Employee J stated that resident was observed to be calm, , and interacting well with staff so we did not call the director back or notify 911. Additionally, Employee J stated that they did not call 911 because the director said not to at that time, if still agitated to send her out, but she was okay and calm. She states that Resident #4 is on psych medications and had been refusing meds for the past few days. Employee J stated that the chain of command is to notify the Med Tech, then the health and wellness director (who was off that night), the director, complete incident report, family contact and fax to the doctor. Employee J stated that they did everything the director advised them to do and that she has not had any training on dealing with combative residents that she can remember.

On at 2:15 PM, review of Resident #4's progress note from the Advanced Registered Nurse Practitioner (ARNP), dated , revealed that "Today staff reports more frequent episodes of aggression, threatening staff, was attempting to strike and was blocked by staff member causing a to right arm, often refusing medications again. Resident does have an appointment with the VA in Brooksville for follow-up on . Patient is agitated and resistive to ROS, she did walk out of interview and was angry." Documented under the Examination section skin indicated that: No or concerning , warm and dry, has purple right with small , no . Under Assessments indicate: of right , of without complication, right, initial encounter. Treatment: of right , monitor with no treatment indicated; of without complication, right, initial encounter, monitor with no treatment needed.

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On at 12:45 PM, review of facility , Neglect & , Policy revealed under policy details #6: External Reporting/Notification (FL Stats. 415. 1034 and 429.23).
a. Notifying Responsible Party. The Executive Director or supervisor on duty should notify the resident's legally responsible party, if there is an allegation of , neglect or , . (1) The notification should occur as soon as practicable. (2) Notification and attempts at notification should be documented in the resident log.
b. Notifying Physician: The Executive Director or supervisor on duty should notify the resident's physician if there is an allegation of resident , neglect or , .
(1) The notification should occur as soon as practicable. (2). Notification and attempts at notification should be documented in the resident log.
c. Report to the Central Hotline. (1) The Executive Director or designee, in consultation with the District/Regional Director of Operations, should report known or suspected , neglect or , and all allegations of , neglect or , to the Department of Children and Families Services Central Hotline. To the extent possible, a report made pursuant to the central hotline must contain, but not be limited to, the following information:
(a) Name, age, race, , physical description and location of the resident is alleged to have been abused, neglected or , . Name, address and telephone numbers of the resident's family members.
(b) Name, address and telephone number of each alleged , , .
(c) Name, address and telephone number of the caregiver of the resident, if different from the alleged , , .
(d) Name, address and telephone number of the person reporting the alleged , neglect or , .
(e) Name, address and telephone number of the person reporting the alleged , neglect or , .
(f) Description of the physical or , , injuries sustained.
(g) Actions taken by the reporter, if any, such as notification of the criminal justice agency.
(h) Any other information available to the reporting person, which may establish the cause of the , neglect or , .
(i) The report should be made as soon as reasonably practicable.
Policy effective date , revised .

On at 2:00 PM, interview conducted with the Executive Director who stated that he did not contact Emergency Medical Service ( ) or the Department of Children and Families (DCF) because Employee C did not indicate that resident #4 obtained an injury to her right arm during the incident, therefore it was not necessary to contact those agencies. The Executive Director stated that the staff informed him that no injury occurred during the incident. Additionally, the Executive Director stated that

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there were no written evidence of the facilities handling of the past three violations, because none occurs.

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