STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965390	**05/30/2017**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE WEST MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7199 GREENBORO DR** **MELBOURNE, FL 32904**	

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

0000 - Initial Comments

Complaint Investigation #2017005518 was conducted on , , and . Brookdale of West Melbourne, License #9766, had a deficiency found at he time visit.

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

Based on record review and interview, the facility failed to ensure 4 of 5 residents lived in a safe and decent living environment, free from , and failed to report suspicions of expressed to them by facility staff (#1, 2, 4 & 5).

Findings:

1. Facility note dated indicated a was noted around resident #1's right inner chin and left upper chin. The resident was unable to state what happened, staff were unaware, and the administrator and hospice were called.

The incident log dated at 7:30 AM indicated that staff C reported that resident #1 leaned forward in her chair during mealtime and hit her chin on the table, causing a on her chin.

Resident #1's record revealed healthcare provider visits on and that indicated diagnoses including , debility-deconditioning. Facility 7-3 shift note indicated a under the resident's chin from leaning forward on the dining table. No facial grimaces were noted, family was notified, and the doctor was informed.

The facility's investigation report indicated resident #1 had a on her chin. She was not combative. She was told she hit her head on the table.

On at 4 PM, resident #1's spouse stated he was aware of a on the resident's chin, but no one could explain why it was there. He said he visits several times every week and she had never had any like that before.

2. An incident report dated at 9:30 AM, reflected staff reported to the resident's chest, right ear, left , skull/scalp, and upper back of resident #5. The caregiver notified the nurse of the .

Resident #5's record revealed a health assessment report dated that indicated diagnoses including and shuffled walk. The facility notes indicated that on at 12 noon, the

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Resident Attendant ( ) noted multiple on the resident's chest, arms and ear. The Power of Attorney (POA) and Primary Care Provider (PCP) were notified. The origin of the were unknown.

The facility's investigation report indicated on , staff a saw a on the chest and each knee on resident #5. She told licensed practical nurse (LPN) B. She heard from the 3-11 shift that she had . The resident was not combative.

On at 9:30 AM, LPN B said C came to her because of reported concerns with N, concerns about resident #5. She added N was rough to the residents.

On at 10:55 AM, C she said that when N provided care to resident #5, he would scream, and flinch when staff V was around him. She said she voiced her concerns to LPN D at approximately , "about one week before the investigation." C confirmed the statements she made in the investigation conducted by the administrator. She said she had worked with N. Some residents avoided N. She said resident #7 was aggressive when N was around. She spoke with LPN D about Staff N when resident #5 was screaming in the hallway and said LPN D would check into it. C said she continued to hear screaming after that. She said that resident #5 was not combative, but did get agitated at times.

On at 11 AM, G said she saw the on resident #5's ear and thought that was very odd. She was concerned and reported the to LPN B, the nurse on duty.

On at 12 PM, LPN D said C reported her concerns with resident #5 on approxiamtely . She examined him and found nothing. She did not do a skin assessment, did not do complete an incident report, and did not report to the Health Wellness Director or the administrator.

On at 11:45 PM, E said she noticed N be rough with a resident, and told a resident she was ugly. She told LPN B about the concerns on about .

3. Resident #2's record revealed she was admitted on and , on . Her most recent Health Assessment dated revealed she required assistance with all activities of daily living (ADLs), except supervision with eating.

Review of the Incident report logs dated , , 2017 for resident #2, revealed entries on the following dates:

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On at 5:30 PM, the incident report log reflected the notified the nurse of a to resident #2's pelvic area while changing the resident, and on at 8:30 AM, a to resident #2's chest and arm was noted. On at 10:55 AM, C stated she saw the and reported them to LPN B.

On , the first day after N was terminated, C reported concerns about resident #2 who had on her legs.

On at 11 AM, G said she saw the on resident #2's chest, and reported it to LPN B, the nurse on duty.

On at 5:45 PM, LPN B said C came to her because of reported concerns with N and the to resident #2. She added N was rough to the residents.

On at 4:45 PM, LPN B confirmed that C had reported the to her and she reported them to the Health and Wellness Director.

4. Review of the record for resident #4, revealed she was admitted on . Her most recent Health Assessment dated revealed diagnoses including and . She was receiving hospice care and required assistance with all ADLs.

An incident report dated reflected that the hospice certified nurse assistant (CNA) reported on the resident's forehead, and that the resident did not know what happened. Earlier in the day, an reported the resident hit her head on the dining .

On at 3 PM, the resident's son stated he was told about the on her forehead and saw it for himself. He said no one was sure how it happened.

On at 4:55 PM, F stated he had been employed at the facility for 4-5 months. He mostly worked the 3-11 shift. He said he worked with N on occasion and said N was disrespectful to the residents, spoke roughly, and moved them forcefully. He said he had not witnessed N hitting anyone.

On at 10:55 AM, C confirmed the statements she made in the investigation conducted by the administrator. She said she had worked with N. She said some residents avoided N. She said resident #7 was aggressive when N was around. She spoke with LPN D about N when resident #5 was screaming in the hallway and said LPN D would check into it. C continued to hear screaming

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after that. She said that resident #5 was not combative, but did get agitated at times. She had no knowledge of the on resident #1's chin.

C said the facility process for reporting suspected or observed is to tell the nurse. After that, go to the Health and Wellness Director, and then the administrator. She said she felt like LPN D would handle it and was still "working on it." It was about 1 week from when she told LPN D to when N was terminated.

On at 11 AM, G said she was trained by N and worked with him about 3 times. She thought he was uninterested in his job and did not care about the residents. She did not feel he manhandled the residents. She said all of the other staff is very kind and gentle with the residents. G stated the process for reporting suspected or observed was to tell the supervisor/nurse on duty. If she heard a resident yelling, she would check on them first and see what was happening.

On at 11:10 AM, /housekeeper K stated he worked with N on several occasions. He said N was a good worker and kind to the residents until sometime around , 2017, then "something changed". He said N pulled the residents roughly when repositioning them in a wheelchair. Even wiping their mouth after a meal seemed more rough than necessary. He said N had a short temper and got "fed up" easily. /housekeeper K said he mentioned this to N directly and N said he'd try to do better. /housekeeper K said that lasted about 1-2 days. He said he did not personally hear any by N to the residents. When asked if he reported any of the rough behaviors, he said he might have told nurse LPN B, but never went to the administrator. He said their process was to tell the nurse.

On at 11:15 AM, dietary manager/cook I said he had worked with N. He said N did not spend the proper amount of time with the residents, he had very little patience. He said N was rough. He never saw him hit anyone. He said resident #7 told him that someone "slapped him in the face" and then resident #7 pointed at N. Dietary manager/cook I did not witness the resident being hit, but he did report it to nurse LPN B, even though the resident was not hurt or . He said he did have training and their process was to report anything immediately to the nurse or to the administrator.

On at 12 PM, LPN D said she worked with N and never witnessed any or rough behavior by N. She stated C did tell her that N had spoken roughly to resident #5. LPN D did not report it to anyone else. She said the 2nd time C told her about N being , two weeks later, she examined resident #5 and saw . At this time, she reported it to the administrator. LPN D stated that the process for reporting is "if I heard about it [ ] more than once, I would

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report it to the Health and Wellness Director or the executive director." LPN D said she thought there was a , conflict between C and N, so she thought the reports were more about that personal difference. She said no other staff ever reported anything to her. She also said she spoke with LPN B, who never thought there was any issue with N.

On at 12:10 PM, LPN M, the Health and Wellness Director said she just started working at the facility on , and she covered all 3 buildings. She said the first she was made aware of was on resident #5's ear and they started an investigation right away. Then she was told about resident #2, and she did a skin assessment.
She said she had met and worked with N. She saw him in the dining the residents. She did not notice anything out of the ordinary but when he wiped the mouth of one resident with a napkin, she said it was "unusual", not rough, just more than needed maybe. She stated no one said anything to her regarding or until the investigation.

On at 11:45 AM, cook E said she worked with N and had reported concerns to LPN B. She witnessed N grab a resident by the arm to move her out of his way. She said she told N that he didn't need to be that way, but he just went on with his work. He said he was very aggressive with resident #5 in his wheelchair, moving too quickly and frightening the resident. She said N also would talk rudely about a resident right in front of them, and said "they don't know what I'm talking about." She heard him tell a resident that she was ugly. Cook E said their process for reporting is to report on the first occurrence. Cook E said she did report to LPN B who said she would watch. Cook E said she believed the nurses had to "see it for themselves" before they could do anything. She did not see any improvement. She stated there was about 1 month between when she spoke to LPN B and when the administrator conducted the investigation.

On at 4:45 PM, LPN B said she had been working at the facility for 4 years as an LPN. She stated she had received the rights and training. She said the process for reporting suspected or observed is for an to tell a nurse, she (the nurse) would check out the resident and document in the resident record (and incident report if needed) what she saw. She would report to the next shift nurse through the "24 hour book" (shift change book). She said she had worked with N on many occasions and he was always a hard worker and very pleasant. About 2-3 weeks before the started being noticed, LPN B said she saw N was more and more agitated and seemed tired. She said he was picking up a lot of extra shifts and was "burnt out". She said she spoke to N, and he just complained that the other shifts were not doing their jobs, and he felt overworked because of it. She first noticed the on resident #5's ear when C brought it to her attention during morning medication rounds. She said she examined the area and then checked other areas of resident #5's body and saw other that were concerning. She said while giving resident #2 her medications one

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morning, she noticed something on her chest, opened her shirt a little, and saw a large area. She said she checked the rest of resident #2 and then alerted the Health and Wellness Director. She said, in retrospect, other residents had seemed fearful of N but since N was terminated, these residents are very calm and much happier. She said one resident would never talk to her if N was nearby and kept saying "bad man, bad man". Another resident had a fearful , from the time he moved in, but it was much worse with N around. She said that resident is now more calm. LPN B stated that anything that was reported to her, she investigated and documented.

On at 5 PM , the administrator acknowledge the findings.

Class II