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	AL11922279	**10/25/2017**
NAME OF PROVIDER OR SUPPLIER **EASTBROOKE GARDENS**	STREET ADDRESS, CITY, STATE, ZIP CODE **201 SUNSET DRIVE** **CASSELBERRY, FL 32707**	

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

0000 - Initial Comments

The re-licensure survey with Extended Congregate Care (ECC) was conducted on , 2017. Eastbrooke Gardens, license #5355, had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure the health assessment form 1823 was complete and accurate for 2 of 2 sampled residents (#11 and #12).

Findings:

1. Record review for resident #12 revealed a health assessment form 1823 that was dated on . The form indicated that resident #12 required medication administration, which the facility's unlicensed staff could not do.

On at 2:42 pm, the director of nursing said the 1823 was incorrect. She said resident #12 required only assistance with self-administration of her medications.

2. Record review for resident #11 revealed a health assessment form 1823 that was not dated and did not contain the address and telephone number of the examining health care provider, as required.

On at 2:50 pm, the director of nursing confirmed the findings.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record reviews and interviews, the facility retained 1 of 7 sampled residents (#11) who exceeded the criteria for continued residency and failed to obtain a new health assessment form 1823 when 1 of 7 sampled residents (#8) experienced a significant change.

Findings:

During an interview with staff C on at 11:15 am, she said resident #11 required total assistance with his Activities of Daily Living (ADLs.)

1. Record review for resident #11 revealed that following a , he was admitted to the hospital on .

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He returned to the facility on with a new and undated health assessment form 1823. A hospital sticker located on the top left corner of the 1823 indicated that he was admitted to the emergency department on .

The new 1823 indicated that resident #11 required total assistance with transferring, he required 24-hour nursing or , care, and his needs could not be met in an Assisted Living Facility, all of which exceeded the criteria for his continued residency.

A home health , note dated on indicated that resident #11 required with all of his ADLs. He was non-weight bearing and a two-person assist for transfers.

On at 2:50 pm, the director of nursing confirmed the findings.

2. Review of the nurse's notes revealed resident #8 was admitted to the hospital on . The reason for the admission was due to a and returned to the facility on . The AHCA form 1823 was dated , the address, telephone number and the examiner's title was left blank. The AHCA form 1823 noted the resident was total with ambulation and posed a danger to self and others.

On at 3:45 PM, the resident care director said she had another AHCA form 1823 that was updated and corrected. The resident care director provided another AHCA form 1823 that was dated , did not include page 1, and did not note whether the residents' needs could be met in an Assisted Living Facility.
The resident care director said at the time the health care provider did not complete the first page of the AHCA form 1823 because page 1 of the other AHCA form 1823 that was dated was going to be used with the updated one, she said she would complete page 1 for the updated form.

Class III

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

Based on observations, record review, medication observation record (MOR) and interview, the facility failed to provide medications as ordered by the Physician for 1 of 7 sampled residents (#12) and did not document the treatment provided for a for 1 of 7 sampled residents (#10).

Findings:

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SUMMARY STATEMENT OF DEFICIENCIES
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1. Record review for resident #10 revealed she was admitted to a rehabilitation center and returned to the facility on . The resident health assessment form 1823 was dated . The form noted she required treatment of Sacral as ordered and hospice services. The section that asked if the resident had any , 3, or 4 pressure , the health care provided noted "yes." The facility's nurse's note documented on care to sacral area was rendered, improving, kept clean and dry as possible. Further record review revealed there were no other facility or hospice notes available for review regarding the stage, measurements of the sacral , or treatment provided.

On at 3:20 PM, the resident care director who was a Licensed Practical Nurse said the resident returned from the rehabilitation center with a pressure . She said the resident also received hospice services. The resident care director said she provided care for the resident when the bandage needed to be changed if hospice was not coming for the day. She said she did make notations of the treatment that she provided, however she could not locate her notes. The resident care director said the had healed and there was no treatment being provided currently. The resident care director said there were no other hospice notes in the record, she contacted the hospice agency and obtained a note that documented on -"facility nurse (name mentioned) advised , is healing almost closed. Advised keep clean and covered for protection."

The resident care director said at the time there were no other notes available regarding treatment of the , .

2. Record review for resident #12 revealed a health assessment form 1823 that was dated on . The form indicated that she had diagnoses of , and and she required medication administration.

A health care provider order that was dated on indicated that she was to take the following medications:

400-microgram (mcg) tablets, take 2 tablets by mouth once daily.

, 40 milligram (mg) tablets, take 1 tablet by mouth once daily and notify a nurse if her , was less than or if her pulse was less than 60.

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50 mg tablets take a half tablet (25 mg) by mouth twice a day and notify a nurse if her was less than or if her pulse was less than 60.

Review of the 2017 Medication Observation Record (MOR) for resident #12 revealed an entry for 400 mcg, take one tablet by mouth daily, which did not match the order given by a health care provider on .

In addition, the entries for her and did not contain instructions to notify a nurse if her pulse was less than 60, as indicated on the order.

Review of the 2017 vital sign history for resident #12 revealed there were no documented pulse readings and no documented on prior to the 5 pm dose of her .

During an interview with the director of nursing on at 4:30 pm, she confirmed the findings.

Class III

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

Based on observations and interviews, the facility failed to post a copy of the Resident Bill of Rights in full view in a freely accessible resident area.

Findings:

During an interview with resident #4 on at 10:15 am, she said she was not informed of her rights. She further stated the facility did not have the Resident Bill of Rights posted.

During an interview with resident #5 on at 10:23 am, she said she was not informed of her rights.

During an interview with resident #15 on at 10:40 am, he said he was not informed of his rights.

Observations made on at 10:55 am revealed a copy of the Resident Bill of Rights was not posted in full view in a freely accessible resident area, as required. A copy of the Rights was posted on a wall in the front entrance of the facility, which was a secured area that the residents did not have access to.

On at 11 am, the administrator confirmed the findings.

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Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on record review, medication observation record (MOR) review and interview, the facility failed to ensure a licensed nurse provided medication administration for 1 of 7 sampled residents (#10).

Findings:

Record review for Resident #10 revealed a health care assessment form 1823 dated . . . . The health care provider noted she needed medication administration (nurse to provide).

Review of the . . . and . . . MOR revealed there were unlicensed staff (non-nurses) initials indicating they were assisting with medications.

On . . . at 3 PM, the resident care director confirmed the 1823 noted Resident #10 required medication administration. She confirmed the unlicensed staff who were not nurses were giving medications to resident #10.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observations, record reviews, and interviews, the facility failed to ensure the personnel record for 1 of 5 staff (D) contained a job description and failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience and allowed unlicensed staff to make a judgement as to whether or not a medication would be given for 2 of 2 residents (#12 and #14).

Findings:

1. Personnel record review for staff D revealed the record did not contain a job description , as required for a facility with a licensed capacity of 17 or more residents.

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On at 6:15 pm, the office manager confirmed the finding.

2. Review of the 2017 Medication Observation Record (MOR) for resident #12 revealed entries for the following medications:

, 40 milligram (mg) tablets, give 1 tablet by mouth daily that was scheduled at 8 am. The nurse was to be notified if the resident's , was less than .

, 25 mg tablets, give a half tablet (25 mg) by mouth twice a day that was scheduled at 8 am and 5 pm. The nurse was to be notified if the resident's , was less than .

The caregiver key on the MOR indicated that the staff initials that signed for the 8 am dose for both of the medications on were those of staff A, an unlicensed caregiver.

3. Observations made during a medication pass for resident #14 on at 5 pm revealed staff F, an unlicensed caregiver, used an electronic , cuff on resident #14 and the results were and a pulse of 78. Staff F reviewed the MOR and said that based on the resident's , and pulse readings, she would give the resident her medications.

Review of the 2017 MOR for resident #14 revealed the entry staff F referred to was for 3.125 mg tablets, give one tablet by mouth twice a day at 8 am and 5 pm. The nurse was to be notified if the resident's , was less than and her pulse was less than 60.

Staff F read the medication label to resident #14 and in the presence of the resident, placed the pill into a cup. The resident took the medication with water. Staff F signed the MOR.

Following the medication pass, staff F said if the resident's , and pulse were less than the parameters set by the health care provider, she would notify the nurse and the nurse would tell her whether she should give the medication or hold it.

During an interview with the director of nursing on at 5:30 pm, she confirmed the process as indicated by staff F. The facility's process allowed unlicensed staff to make a judgement as to whether or not a medication would be given.

Class III

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

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Based on record reviews and interview, the facility failed to maintain an accurate staffing schedule.

Findings:

Review of the facility's 2017 staffing schedule revealed only unlicensed caregivers were listed on the schedule.

During an interview with the director of nursing on at 5 pm, she said a licensed nurse was in the facility 7 days a week and at all times, the licensed nurse assisted the residents with their medications, which required the nurse's hours to be included on the staffing schedule. The director of nursing confirmed the facility's schedule did not list the nurses.

Class

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on the personnel record review and interview, the facility failed to ensure that unlicensed staff providing assistance with self-administration of medications completed the 2 hour of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility for 1 of 4 sampled staff (A).

Findings:

Staff A's personnel record review revealed date of hire , there was no documentation of the 2 hours annual medication update training for 2017 as required.

On at 5 PM, an interview with the Business Office Manager who confirmed the finding.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on the personnel record review and interview, the facility failed to have documentation for the 4 hours and Related (ADRD) trainings to include 4-hours Level 1 within 3 months of employment, 4 -hours Level 2 within 9 months of employment, and thereafter 4-hours annual continued education completed by an approved trainer of Department of Elder Affairs (DOEA) for 3 of 4 sampled staff (A, B, and C) as required for special care for persons with ADRD and are maintained in a secured area.

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Findings:

1. Staff A's personnel record review revealed no documentation of the missing 4-hours Level 1, 4-hours Level 2, and the 4 hours annual update ADRD training by an approved trainer. Date of hire .

2. Staff C's personnel record review revealed no documentation or missing 4-hours Level 1 ADRD training by an approved trainer. Date of hire .

On at 5 PM, an interview with the Administrator who confirmed the findings.

3. Personnel record review for staff B hired revealed she had obtained her 's Level 1 and Level 2 on . There was no documentation staff B had the continuing education as required annually.

The business office manager was given the opportunity to provide evidence of the training to the area office on by 11 AM. The information was not provided.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on the personnel record review and interview, the facility failed to maintain documentation to ensure that 3 of 4 sampled staff (A, B and C) completed 1-hour ( ) training within 30 days after employment as required.

Findings:

1. Staff A's personnel record review revealed no documentation of the 1-hour training. Date of hire .

2. Staff B's personnel record review revealed no documentation of the 1-hour training. Date of hire .

3. Staff C's personnel record review revealed no documentation of the 1-hour training. Date of hire .

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On at 5 PM, an interview with the Business Office Manager who confirmed the findings.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on the facility's admission and discharge log and interview, the facility failed to maintain an up-to-date admission and discharge log for 1 of 14 sampled residents (#7).

Findings:

The admission and discharge log revealed that resident #7 was admitted to the facility on . Further review revealed there was no date of discharge documented.

On at 4 PM, an interview with the Administrator who confirmed the finding.

Class

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility provided care treatment to 1 of 7 sampled residents (#10) and did not have evidence in the record of a health care providers order for the nursing service/treatment.

Findings:

Record review for resident #10 revealed she was admitted to a rehabilitation center in and returned to the facility on . The resident health assessment form 1823 was dated and noted she required treatment of Sacral as ordered and hospice services. The section that asked if the resident had any , 3, or 4 , the health care provided noted "yes." The facility's nurse's note documented on care to sacral area was rendered, improving, kept clean and dry as possible. Further record review revealed there were no other facility or hospice notes or orders for treatment available for review regarding the stage, measurements of the sacral , or treatment provided. There were no health care providers orders found in the record.

On at 3:20 PM, the resident care director who was a Licensed Practical Nurse (LPN) said the

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resident returned from the rehabilitation center with a . She said the resident also received hospice services. The resident care director said she provided care for the resident when the bandage needed to be changed if hospice was not coming for the day. She said she did make notations of the treatment that she provided, however she could not locate her notes. The resident care director said the had healed and there was no treatment being provided currently. The resident care director said she used the hospice agency's physician's orders for treatment. She said she had contacted the hospice agency for the physician's order because it was not located in the resident's record.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on contract review and interview the facility failed to ensure that each resident contract contained the rights, duties and of residents, other than those specified in the Resident Bill of Rights for 2 of 2 sampled resident's contracts (#8 and #12).

Findings:

Review of the contracts for resident #8 dated and resident #12 dated revealed it noted, "In the event that the Residence intends to make a claim against the Security Deposit, the Residence shall notify Resident of the claim verses the Security Deposit and provide the Resident fourteen (14) calendar days to respond."
Further review of the contract revealed the contract only mentioned a refund of the security deposit and did not included a claim against any other type refund as required and that the resident would be notified in writing.

The following components were missing from the contract:
Per 429. 24 there was no provision that indicated that if after a contract was terminated, the facility intended to make a claim against a refund due the resident, the facility must notify the resident or responsible party in writing of the claim and must provide the said party a reasonable period of time of no less than 14 calendar days to respond.

There was also no provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule;
On at 2 PM the administrator reviewed the contract and confirmed the findings,

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Class

E210 - ECC - Training - 58A-5.0191(7) FAC

Based on personnel record review and interview, the administrator failed to obtain 4 hours of initial training in Extended Congregate Care (ECC).

Findings:

Personnel record review for Staff E, the administrator revealed there was a change of administrator form completed in appointing her as the administrator.

Further personnel record review revealed there was a certificate for 2 hours of ECC training on .

On at 3 PM, the business office manager confirmed the findings and stated she was not aware the administrator was required to obtain 4 hours of the initial ECC training.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on personnel record reviews, review of the Agency's background screening clearing house, and interview, the facility failed to maintain an employee roster on the Agency's background screening clearing house that listed 1 of 5 sampled staff (D) who was subject to a background screening.

Findings:

Personnel record review for staff D, a nurse, revealed a hire date of .

Review of the Agency's background screening clearing house revealed that staff D was not listed on the facility's roster, as required.

On at 3:35 pm, the office manager confirmed the finding.

Unclassified