STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964912	01/04/2018
NAME OF PROVIDER OR SUPPLIER **BROOKDALE SOUTHPOINT**	STREET ADDRESS, CITY, STATE, ZIP CODE **6895 BELFORT OAKS PLACE** **JACKSONVILLE, FL 32216**	

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

0000 - Initial Comments

A complaint investigation (CCR #2017011894) was conducted at Brookdale Southpoint Assisted Living Facility (License #9380) on . Deficiencies were identified.

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

Based on observation, interview, and record review, the facility failed to ensure the rights of all 20 residents on the memory care unit were protected, evidenced by the unsupervised behvaiors of 1 of 20 residents (Resident #1) which included wandering into uninvited and taking personal property, including other residents' food, and ingesting nonfood items. The right to privacy for one resident (Resident #4) was not protected when a third party provider conducted an examination of the resident and discussed her health status in the dining the lunch meal service in front of the other residents and staff on the unit.

The findings include:

On , during the breakfast meal service on the memory care unit, observations were made from 7:45 am until 8:40 am. Resident #1 was observed lying on his bed until 8:05 am. He was brought to the dining Employee B. He was led by the hand and walked independently. At 8:10 am, he got up and left the dining . He was escorted back to the dining the administrator at 8:12 am. A staff member escorted him to his table again and he sat down. Resident #1 was observed to get up and leave the table again at 8:14 am. He went to his . His located directly across from the dining the memory care unit. He was escorted back to the dining and sat at his table. He was served breakfast at 8:15 am. He sat and ate his breakfast independently. He was served two full meals. At 8:50 am, he went and laid down on his bed.

On at 8:30 am, the administrator was interviewed. During the interview, both this surveyor and the administrator observed Resident #1 walk continuously on the unit from 8:40 am to 8:50 am. She stated that Resident #1 is known to walk the unit almost continuously while awake. Other behaviors she mentioned were wandering into other residents' , and taking food off other residents' plates. Interventions in place are to keep the doors to other residents' closed, except for Resident #1's, because he knows his will go to his redirected by staff. She confirmed that staff has to keep him out of other's and stay right with him to redirect him, because he is fast and they are busy with the other twenty residents on the unit. She said it is her belief that the staff does a good job to try to keep up with the resident. She stated the staffing ratio on the locked unit is always three staff for each shift.

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During an interview with Employee A on at 8:57 am, she stated that Resident #1 goes into other resident's and gets in their beds. She referenced a time when he got in the bed with a female resident (who is no longer at the facility). She confirmed he grabs food off the other resident's plates during meals. She said he does it "all the time". She stated she felt there is nothing they can do to stop him because he is "out of his mind" and he does not understand. When they find him in other people's , they redirect him. She stated she is very familiar with Resident #1's behavior, because she works on the memory care unit, most of the time.

During an interview on at 9:40 am with Employee D, she stated that Resident #1 goes into other residents' ; gets in their beds; sits in their recliners and takes food off their plates. She stated he is fast and can go into another resident's the staff being aware and then they have to go look for him. She confirmed knowledge that he has gotten into bed with female residents before. She stated other residents have struck him when he takes their food or goes into their . She expressed concern that he might get hurt. When asked if the facility has tried him on one-to-one supervision, she stated this was recommended to Resident #1's wife, but she did not want him to be on one-to-one supervision.

Employee D was asked to describe any other behaviors that Resident #1 exhibited. She stated he picks non-food items up off the floor, on the ground outdoors, or on the unit (other residents') and puts them in his mouth. She said she once put a new shirt on him that had a crew neck collar (rounded around the neck). She checked on him later and he had chewed the shirt so much it looked like a V-neck collar. She changed the shirt, putting another new crew-neck shirt on him. He chewed the new one also, so much so, that it looked like a V-neck. She checked his mouth but did not find any pieces of the shirt so she assumed he had swallowed it. She said she has had to pry non-food items out of his mouth. She indicated he is very quick and if the staff is not right with him, he ingests things before they can stop him.

During an interview with Employee B on at 9:20 am, she stated Resident #1 wanders into residents' and take food off their plates. She said the staff gives him extra portions with each meal but he still takes food from other residents if it is available. She stated that there have been complaints by other family members about Resident #1's behavior. The facility has put interventions in place to try to stop him from going into other residents' but they do not always work. They try to keep the doors to the residents' and leave his open. His right across the hall from the dining area. Employee B said when they see him wandering down the hallways, staff has to monitor him and verbally redirect him. Sometimes they have to redirect him physically.

During an interview with Employee C, Health and Wellness Coordinator, on at 9:30 am, it

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was confirmed that Resident #1's behaviors included wandering around the unit, entering other residents' and taking other residents' food off their plates. Employee C stated Resident #1 is very hard to supervise because he ambulates independently and can walk fast. His wife has been approached about having a private caregiver to be with him one-to-one and she got upset whenever the facility tried to discuss this need with her.

On at 9:50 am, # was observed to have two spray bottles of chemical cleaner on the dresser next to the A-bed. Both bottles had labels with warnings against ingestion. Photographic evidence obtained.

On at 10:12 am, Resident #1 was observed to go into the dining serve himself a glass of apple juice. He picked up the pitcher off the counter and started to take the plastic wrap off. Employee B came over to him and assisted him. She poured him a glass of juice. He went to a table and sat down. After a couple of minutes, he was observed to get up, walk across the dining , across the hall and into . He was observed lying on the bed near the window sipping his juice. The bed was Resident #6's bed. He laid on the bed for 10 minutes, and then staff redirected him to his own .

During a second interview with Employee D and Employee B at 10:15 am in , both stated that the his behavior is infringing on other people's rights and he needs to be on one-to-one supervision for his own safety. When shown the spray bottles of chemical cleaners left in # while Resident #1 was in there, they acknowledged that he could have opened them and drank them. They agreed that putting non-food items in his mouth and swallowing them could be harmful to him.

Review of the medical record for Resident #1 revealed he was admitted on . The Health Assessment (form 1823) dated revealed the resident's diagnoses were Hematoma, Aphasia, Hypernatremia, Frontal , due to , ( ), and Weight loss. The resident was assessed as having and memory ; being an elopement risk; requiring assistance with bathing, dressing and self-care ( ); and being independent with ambulation and transfers. The resident requires assistance with preparing meals, shopping, making phone calls, handling personal affairs and handling financial affairs. The resident requires general oversight in the areas of observing his well-being, whereabouts and to remind him of important tasks. He requires assistance with medication self-administration. Photographic evidence obtained.

Review of the facility Care Profile for Resident #1 dated showed the following: Staff would provide structure, attention or assistance to accomplish and/or participate in daily routines due to

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memory loss or . Further details stated Resident #1 wanders and requires redirection; Resident #1 removes personal property of others; and Resident #1 has sleep/wake disturbances. The form also indicated that the facility would provide additional staff involvement because Resident #1 demonstrates , disruptive or behaviors requiring additional attention.

Review of the progress notes dated (1 day after admission) read "Resident continues to walk constantly from , removing items from others resident's . Activities and redirection tried. Resident not able to understand". Photographic evidence obtained.

Review of the progress notes dated read "Resident observe wandering on unit. Resident constantly in and out of other resident's . Resident verbally redirected to not enter other resident's ". Photographic evidence obtained.

Review of the progress notes dated read "Resident continues to wander around unit". Photographic evidence obtained.

During an interview with Resident #5 on at 11:55 am, she stated she is very familiar with Resident #1's behavior. She confirmed that he wanders the unit, unsupervised, goes into other residents' , takes food off other's plates and puts it right in his mouth. She confirmed he has gone into her taken things out of it. She said she tells staff and they usually find her things in his . She tries to keep him out of her she is in it by keeping the door shut. She shuts the door when she is out of her she has seen him open the doors to the other residents' so she knows he can open hers too. She stated she used to have ice trays in the freezer section of the refrigerator in the dining . Resident #1 would go into the freezer and eat the ice or take the trays to his let them melt. Staff no longer allows her to keep ice trays in the freezer because of his behavior. She has to go to the other end of the building to get ice now.

The lunch meal service was observed from 12:00 pm until 1:15 pm. Resident #1 was given two plates of food and two pieces of pie. He was observed to eat 100% of the food. He sat at his table for 15 minutes after finishing his meal. He then got up and was seen pacing around the unit, walking through the dining area even as the other residents were eating, and staff was trying to clean up the . At 1:10 pm, he was observed to go to the refrigerator in the dining , open it and take out a plate of food covered with a napkin. The staff went to him, took the plate of food away from him and put it back in the refrigerator. It was explained to him that the plate of food was for someone else. He then walked out of the dining continued pacing around the unit by himself.

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During the lunch meal service, a nurse from a third party hospice provider entered the locked unit. She had a stethoscope around her neck. She carried a black medical bag. She went to Resident #4, who was seated in the dining a table with two other female residents. She began asking her questions. She donned a pair of pink latex gloves and proceeded to conduct a full routine physical examination/assessment of the resident. She listened to her lung sounds with the stethoscope. She examined her eyes with an ophthalmoscope. She felt her legs/ankles; made the resident hold her hands and squeeze them as tight as she could; asked the resident how she felt. She examined the resident's scalp and announced to the staff in the she did not see any /laceration on her head. She discussed the resident's medical condition with Employee A in front of the two residents at her table and anyone else within earshot. She stated she did not find any laceration or on the resident's scalp and had examined her for . This surveyor heard it from across the .

Review of the posted Bill of Rights for Residents of an Assisted Living Facility revealed the residents have the right to live in a safe living environment, free from hazards. They have the right to privacy of their own possessions, and medical information. They have the right to be treated with dignity and respect. They have the right to receive appropriate medical care.

Class III

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

Based on observation, interview, and record review, the facility failed to provide staffing to meet the needs of one resident (Resident #1, known to have behaviors such as wandering, placing nonfood items in his mouth, and taking people's belongings) out of 3 sampled residents on the locked memory care unit.

The findings include:

On , during the breakfast meal service on the memory care unit, observations were made from 7:45 am until 8:40 am. Resident #1 was observed lying on his bed until 8:05 am. He was brought to the dining , Employee B. He was led by the hand and walked independently. At 8:10 am, he got up and left the dining . He was escorted back to the dining , the administrator at 8:12 am. A staff member escorted him to his table again and he sat down. Resident #1 was observed to get up and leave the table again at 8:14 am. He went to his . His located directly across from the dining the memory care unit. He was escorted back to the dining and sat at his table. He was served breakfast at 8:15 am. He sat and ate his breakfast independently. He was served two full meals. At 8:50 am, he went and laid down on his bed.

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On at 8:30 am, the administrator was interviewed. During the interview, both this surveyor and the administrator observed Resident #1 walk continuously on the unit from 8:40 am to 8:50 am. She stated that Resident #1 is known to walk the unit almost continuously while awake. Other behaviors she mentioned were wandering into other residents' , and taking food off other residents' plates. Interventions in place are to keep the doors to other residents' closed, except for Resident #1's, because he knows his will go to his redirected by staff. She confirmed that staff has to keep him out of other's and stay right with him to redirect him, because he is fast and they are busy with the other twenty residents on the unit. She said it is her belief that the staff does a good job to try to keep up with the resident. She stated the staffing ratio on the locked unit is always three staff for each shift.

Review of the staffing schedules for , 2018 revealed the memory care unit was fully staffed with three caregivers for each shift. The unit was fully staffed during this survey.

During an interview with Employee A on at 8:57 am, she stated that Resident #1 goes into other resident's and gets in their beds. She referenced a time when he got in the bed with a female resident (who is no longer at the facility). She confirmed he grabs food off the other resident's plates during meals. She said he does it "all the time". She stated she felt there is nothing they can do to stop him because he is "out of his mind" and he does not understand. When they find him in other people's , they redirect him. She stated she is very familiar with Resident #1's behavior, because she works on the memory care unit, most of the time.

During an interview on at 9:40 am with Employee D, she stated that Resident #1 goes into other residents' ; gets in their beds; sits in their recliners and takes food off their plates. She stated he is fast and can go into another resident's the staff being aware and then they have to go look for him. She confirmed knowledge that he has gotten into bed with female residents before. She stated other residents have struck him when he takes their food or goes into their . She expressed concern that he might get hurt. When asked if the facility has tried him on one-to-one supervision, she stated this was recommended to Resident #1's wife, but she did not want him to be on one-to-one supervision.

Employee D was asked to describe any other behaviors that Resident #1 exhibited. She stated he picks non-food items up off the floor, on the ground outdoors, or on the unit (other residents') and puts them in his mouth. She said she once put a new shirt on him that had a crew neck collar (rounded around the neck). She checked on him later and he had chewed the shirt so much it looked like a V-neck collar. She changed the shirt, putting another new crew-neck shirt on him. He chewed the new one also, so much so, that it looked like a V-neck. She checked his mouth but did not find any

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During an interview with Employee C, Health and Wellness Coordinator, on at 9:30 am, it was confirmed that Resident #1's behaviors included wandering around the unit, entering other residents' and taking other residents' food off their plates. Employee C stated Resident #1 is very hard to supervise because he ambulates independently and can walk fast. His wife has been approached about having a private caregiver to be with him one-to-one and she got upset whenever the facility tried to discuss this need with her.

On at 9:50 am, # was observed to have two spray bottles of chemical cleaner on the dresser next to the A-bed. Both bottles had labels with warnings against ingestion. Photographic evidence obtained.

On at 10:12 am, Resident #1 was observed to go into the dining serve himself a glass of apple juice. He picked up the pitcher off the counter and started to take the plastic wrap off. Employee B came over to him and assisted him. She poured him a glass of juice. He went to a table and sat down. After a couple of minutes, he was observed to get up, walk across the dining , across the hall and into . He was observed lying on the bed near the window sipping his juice. The bed was Resident #6's bed. He laid on the bed for 10 minutes, and then staff redirected him to his own .

During a second interview with Employee D and Employee B at 10:15 am in , both stated that the his behavior is infringing on other people's rights and he needs to be on one-to-one supervision for his own safety. When shown the spray bottles of chemical cleaners left in # while Resident #1 was in there, they acknowledged that he could have opened them and drank them. They agreed that putting non-food items in his mouth and swallowing them could be harmful to him.

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Review of the facility Care Profile for Resident #1 dated showed the following: Staff would provide structure, attention or assistance to accomplish and/or participate in daily routines due to memory loss or , . Further details stated Resident #1 wanders and requires redirection; Resident #1 removes personal property of others; and Resident #1 has sleep/wake disturbances. The form also indicated that the facility would provide additional staff involvement because Resident #1 demonstrates , disruptive or behaviors requiring additional attention.

Review of the progress notes dated (1 day after admission) read "Resident continues to walk constantly from , removing items from others resident's . Activities and redirection tried. Resident not able to understand". Photographic evidence obtained.

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Review of the progress notes dated read "Resident continues to wander around unit". Photographic evidence obtained.

The lunch meal service was observed from 12:00 pm until 1:15 pm. Resident #1 was given two plates of food and two pieces of pie. He was observed to eat 100% of the food. He sat at his table for 15 minutes after finishing his meal. He then got up and was seen pacing around the unit, walking through the dining area even as the other residents were eating, and staff was trying to clean up the . At 1:10 pm, he was observed to go to the refrigerator in the dining , open it and take out a plate of food covered with a napkin. The staff went to him, took the plate of food away from him and put it back

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Class III