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	AL11965390	**01/08/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE WEST MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7199 GREENBORO DR** **MELBOURNE, FL 32904**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

The re-licensure survey including Limited Nursing Services was conducted on . . . . . Brookdale West Melbourne Assisted Living Facility, License #9766, 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 review and interview, the facility did not obtain a complete and accurate Resident Health Assessment form (AHCA form 1823) for 1 of 2 sampled residents (#2).

Findings:

Resident #2's record revealed a resident health assessment 1823 form that was dated . The health care provider noted that the resident required medication administration (nurse required), and the resident required assistance with the self-administration of her medication. There was no way to determine whether the resident needed her, medications administered or needed assistance.

On at 10:30 AM, an interview was attempted with resident #2 but due to her , she was unable to answer questions appropriately.

On . . . . . at 2 PM, the health and wellness director confirmed the findings.

Class III

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

Based on observations, record reviews and interviews, the facility failed to follow an order from a health care provider for 1 of 2 sampled residents (#2), and failed to intervene and notify hospice, a health care provider, and family when 1 of 2 sampled residents experienced a significant weight loss (#1).

Findings:

1. On at 10:30 a.m., the health and wellness director identified resident #2 and said she received a Limited Nursing Service (LNS) for a compression stocking to her right leg.

On . . . . . at 11 a.m., resident #2 sat on a bench in a hallway. She did not have a compression stocking on her right leg.

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On at 11:05 a.m. nurse F said resident #2 did not have the stocking on because she had not gotten to it yet.

During an interview with the husband of resident #2 on at 11:20 a.m., he said the day of the interview was the first day in the last 4-5 days that the facility staff applied the stocking to her leg.

Record review for resident #2 revealed an order from a health care provider, dated , for the right leg compression stocking to be applied every morning and removed every evening.

2. Record review for resident #1 revealed a documented weight of 139 pounds (lb.) on , 112 lb. on , and 117 lb. on .

The record for resident #1 contained no documented evidence to indicate the facility notified hospice, a health care provider, and her family when she lost 27 lb. between 2017 and 2017.

In addition, the record for resident #1 contained no documented evidence to reflect the facility implemented any interventions to prevent further weight loss.

On at 4:30 p.m., the health and wellness director confirmed the findings.

Class III

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observations and interviews, the facility failed to provide timely assistance to a resident (#1) who required assistance with toileting.

Findings:

Observations made of resident #1 on at 11:50 a.m. revealed she was reclined in a wheelchair in her . The an odor of stool and observations revealed the resident's pants were wet.

During an interview with nurse F on at 11:50 a.m., she confirmed resident #1 was soiled and said the last time the caregiver assisted the resident with incontinence care was at 10 a.m.

During an interview caregiver B on at 12 p.m., she said the last time she provided incontinence

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care to resident #1 was when she got her out of bed before 7 a.m.

Resident #1's record revealed a health assessment form 1823, dated on that indicated she required assistance with toileting and she had a diagnosis of 's .

In addition, a care note dated on at 2 p.m. indicated resident #1 was unable to make her needs known.

Class III

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

Based on observations, record reviews and interviews, the facility failed to honor the rights of a resident (#1) who was restrained and in her .

Findings:

Observations made on at 10:15 a.m. revealed a group of residents seated together in the facility's Life Enrichment .

During a tour of the facility on at 10:50 a.m., a voice was heard repeatedly yelling out. Observations revealed resident #1 was alone in a wheelchair in her . She faced the wall and did not have any sensory stimulation, such as music or television. The back of her wheelchair was reclined back, and the footrest was elevated, which placed her in a near supine position and physically limited her movement. She responded to questions by continuously yelling out.

During an interview with caregiver B on at 11:05 a.m., she said resident #1 was alone in her her yelling upset the other residents, and for her own protection because she was almost slapped by another resident. She said the resident's chair was reclined with the feet elevated to prevent her from falling forward.

Almost one hour later on at 11:48 a.m., resident #1 remained alone in her in the same position as previously observed. At that time, nurse F said resident #1 was kept in her her yelling agitated the other residents and for her safety because she had previously been yelled at and slapped by another resident. She said her wheelchair was reclined and elevated for positioning.

Resident #1's record revealed she had a diagnosis of 's , required assistance with all

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of her care, and was at risk for . A care note dated on 11/ indicated she was unable to make her needs known. On on the 7 a.m.-3 p.m. shift, she out of her wheelchair in the TV . A hospice note dated on indicated her wheelchair should be positioned to a slight recline.

Observations made throughout the survey revealed resident #1 was not present during resident activities.

During an interview with the administrator on at 4:45 p.m., she said resident #1 should not have been to her . She said resident #1 was usually placed in the facility's TV lounge.

Observations made throughout the survey revealed other residents did not use the TV lounge and activities were not provided in the lounge.

Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observations, record review and interview, the facility failed to ensure 1 of 1 sampled residents (#2) assessed as elopement risk had identification on her person at all times (#2).

Findings:

Record review for resident #2 revealed a health assessment form 1823 dated the health care provider noted on the 1823 form that resident #2 was an elopement risk.

On at 10:30 AM, an interview was attempted with resident #2 but due to her , she was unable to answer questions appropriately.

On at 2:20 PM, resident #2 was observed sitting in her , the wellness care director attempted to awaken the resident. The wellness care director lifted the resident's sleeves on of both the resident arms. The Wellness Director stated the resident must have taken the identification off.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on medication observation record (MOR) review and interview, the facility failed to maintain accurate MORs for 2 of 2 sampled residents (#1 & 2).

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Findings:

1. Review of the MOR for [redacted] and [redacted] for resident #2 revealed there were blank spaces and there was no way to determine whether the resident received her medications. Some examples are as follows:

10 milligrams (mg.) one at bedtime was left blank at 10 PM was left blank on [redacted], [redacted], [redacted] and [redacted].

[redacted] HCl tablet 100 mg. give 2.5 in the afternoon for behaviors was left blank at 3 PM on [redacted],

[redacted] HCl 100 mg. give 3 tablets at bedtime for sleep was left blank at 10 PM on [redacted] and [redacted].

2. Record review for resident #1 revealed a health assessment form 1823, dated on [redacted] that indicated she required medication administration.

Review of the [redacted], 2018 MOR for resident #1 revealed entries for the following medications:

60 milligram (mg.) tablets, give 1 tablet by mouth three times a day for [redacted]. The 10 p.m. dose on [redacted] and the 2 p.m. dose on [redacted] were blank and not signed as given.

[redacted], 50 mg. tablets, give 1 tablet by mouth three times a day for behavior. The 2 p.m. dose on [redacted] was blank and not signed as given.

The MOR and the record for resident #1 did not contain documentation to indicate why the MOR was blank.

On [redacted] at 4:45 p.m., the health and wellness director confirmed the findings and was unable to provide an explanation.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observations, record reviews, and interview, the facility failed to ensure a medication container was properly labeled for a resident who received medication administration (#1).

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Findings:

Observations made during a medication pass for resident #1 on at 11:48 a.m. revealed nurse F gave resident #1 a tablet from a medication container in which the directions for use on the prescription label indicated 500 milligram (mg.) tablets, give 1 tablet by mouth twice daily.

Review of the 2018 Medication Observation Record (MOR) for resident #1 revealed the directions for use indicated the was to be given three times a day.

The container did not contain an alert label that directed staff to examine the revised directions for use in the MOR, as required.

On at 11:50 a.m., nurse F confirmed the findings and said she did not know why the directions for use on the medication container differed from those on the MOR.

Record review for resident #1 revealed an order from a health care provider, dated on , for 500 mg. by mouth three times a day. In addition, a health assessment form 1823, dated on , indicated she required medication administration.

Class III

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

Based on observations, record review, personnel record review, and interview the facility allowed unlicensed staff to give medications to a resident (#1) who required medication administration, failed to ensure 1 of 5 sampled staff (A) had documentation of annual assessment for ( ) signed by the healthcare provider and 2 of 4 sampled staff (A & B) had freedom a freedom from communicable statement and failed to ensure 1 of 5 staff members (E) submitted a written statement from a health care provider documenting freedom from communicable within 30 days after beginning employment.

Findings:

1. Personnel record review for staff A, the administrator, hired . The last documentation to confirm she was free from was dated 11/ . There was no documentation to confirm she was free from communicable .

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Personnel record review for caregiver B, hired , revealed there was a statement dated on the facility's letterhead documenting freedom from communicable . The signature on the form was not legible. There was no way to determine the credentials of the person completing the form there was not title. The section for the name address and telephone number was left blank on the form.

On at 4 PM, the administrator said she had her annual test and freedom from communicable and said it was not in her record.

2. Observations made during a medication pass for resident #1 on at 11:48 a.m. revealed nurse F crushed the resident's medication, mixed it in applesauce, and then used a spoon to feed the mixture to the resident.

Record review for resident #1 revealed a health assessment form 1823, dated on that indicated she required medication administration.

During an interview with the health and wellness director on at 4:20 p.m., she confirmed resident #1 required administration of her medications and she identified the initials that were documented on the Medication Observation Record (MOR) to indicate the resident received her evening medications on through were those of an unlicensed staff member.

3. Personnel record review for nurse E revealed a hire date of . The record did not contain a written statement from a health care provider documenting that staff E did not have any signs or symptoms of communicable , as required.

On at 4:30 p.m., the business office manager confirmed the findings.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on personnel record review and interview the facility failed to ensure that 4 of 5 sampled staff (B, C, D & E) received the required in-service training within 30 days of hire.

Findings:

1. Personnel record review for caregiver B hired and she provided personal care to the resident did not evidence in her record to confirm a 3-hour in-service in 30 days for Resident behavior and needs

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and providing assistance with the activities of daily living. The facility was given the opportunity to send the certificate via email to the agency by .

On at 10 AM, the administrator provided the certificate via email. Review of the certificate revealed it was dated and was for only 1 hour (3 were required). At 10:17 AM an email was sent to the administrator informing her the training was only 1 hour, a response was not received from the administrator.

2. Personnel record review for caregiver C revealed a hire date of .

3. Personnel record review for caregiver D revealed a hire date of .

4. Personnel record review for nurse E revealed a hire date of .

The personnel record for caregivers C and D did contain documented evidence to indicate they received 3 hours of in-service training that covered resident behavior and needs and providing assistance with the activities of daily living, as required.

5. The personnel record for nurse E did not contain documented evidence to indicate she received in-service training that covered facility emergency procedures including chain-of- command and staff roles relating to emergency evacuation, resident rights in an assisted living facility, and recognizing and reporting resident , neglect, and , , as required.

On at 4:50 p.m., the business office manager confirmed the findings.

Class III

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

Based on personnel record review and interview the facility maintained a secure area and provided special care for persons with 's and related (ADRD), failed to ensure that 4 of 5 sampled staff (B, C, D & E) who provided direct care to persons with 's and Related (ADRD) obtained 4 hours of initial training within 3 months of employment that was provided by an approved ADRD Trainer.

Findings:

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1. Personnel record review for caregiver B, hired . . . . , had no documentation to confirm she obtained the 4-hour initial ADRD training. The facility was given the opportunity to send the certificate via email to the agency by . . . . .

On . . . . . at 10 AM, the administrator provided the certificate via email. Review of the certificate revealed it was dated and was signed by the administrator. There was no way to determine whether she was an approved ADRD trainer.

On . . . . . at 10:17 AM, an email was sent to the administrator requesting documentation that she was an approved ADRD trainer. A response was not received from the administrator.

2. Personnel record review for caregiver C revealed a hire date of . . . . .

3. Personnel record review for caregiver D revealed a hire date of . . . . . .

4. Personnel record review for nurse E revealed a hire date of . . . . .

The personnel record for caregivers C, D, and nurse E did not contain documented evidence to indicate they obtained 4 hours of initial training in the topic of ADRD, as required.

On at 4:30 p.m., the business office manager confirmed the findings.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, menu review and interview the facility failed to have substitutions with items of comparable nutritional value, substitutions were noted were before or when the meal was served and did not maintain a 3-day emergency supply water on hand to meet the needs of the 25 residents in the event of an emergency.

Findings:

Review of the menu that was posted in the dining it noted marinated vegetable salad, veal parmesan, pasta of the day, buttered California mix and creamy pudding was to be served.

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On at 12:30 PM, observations of the meal served revealed a 3-bean salad was served, veal parmesan mixed in a tomato sauce with the pasta and pudding. There was no buttered California mix served.
There were no substitutions posted in the dining .

Review of the substitution log revealed for that the 3-bean salad was substituted for the marinated vegetable salad. There was no substitution for the buttered California mix.

On at 1 PM, the kitchen manager said the buttered California mix was not delivered to the facility and he confirm the substitution was not noted on the menu for the residents.

Observations on at 1:15 PM of the emergency water revealed there were only 18 gallons of water in the event of an emergency for the 25 residents of the facility.

On at 1:15 PM, the kitchen manager confirmed the findings.

Class III

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

Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide a safe living environment for the 25 residents of the facility.

Findings:

Observations on at 9:50 AM revealed in the from the life enrichment , the air vent was covered with a black substance and the ceiling tiles were stained. Further observations revealed there was also the same type of black substance covering the air vents in the life enrichment , also the vent in the TV lounge.

On 10 AM the administrator confirmed the findings in the life enrichment . On at approximately 11:30 AM, the vent was cleaned in the life enrichment . However, the other areas found remained covered with the black substance.

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0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on personnel record reviews and interview, the facility failed to ensure the staff record contained a copy of the job description for 1 of 5 sampled staff (E).

Findings:

Review of the facility's posted license revealed it was licensed for a capacity of 42.

Personnel record review for staff E, a nurse, revealed the record did not contain a copy of her job description, as required.

On at 4:30 pm, the business office manager confirmed the finding.

Class

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

Based on observations, record review, and interview, the facility failed to ensure a resident record (#1) included an order for a therapeutic diet and an order to crush medications.

Findings:

Observations made during a medication pass for resident #1 revealed staff F, a nurse, crushed the resident's medication, mixed it in applesauce, and then used a spoon to feed the mixture to the resident.

Observations made during the lunch meal on at 12:15 pm revealed resident #1 was fed a pureed meal.

Record review for resident #1 revealed a health assessment form 1823, dated on that indicated her diet instructions were to have nothing by mouth. The record did not contain an order from a health care provider to give her a pureed diet, as required.

In addition, the record for resident #1 did not contain an order from a health care provider to crush her medications, as required.

On at 4:15 pm, the health and wellness director confirmed the findings.

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Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on interview, the facility did not have evidence that the comprehensive emergency management plan was submitted for review and approval to the local emergency management agency.

Findings:

On at 10 AM, the administrator was asked to provide the approval letter for the facility's Comprehensive Emergency Plan (CEMP).

On at 4:45 PM, the administrator said the facility had submitted their plan for review and did not have any documentation to confirm their plan had been submitted.

Class III

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on observations, record reviews, and interviews, the facility failed to ensure nursing services were conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community and allowed a Licensed Practical Nurse (LPN) to conduct a nursing assessment for 1 of 2 residents (#1) who received a Limited Nursing Service (LNS,) and failed to ensure the application of a dressing was authorized by a health care provider's order for 1 of 2 sampled residents (#1).

Findings:

1. Observations made of the facility's posted license on at 10 am revealed the license contained a designation for LNS.

On at 10:30 am, the health and wellness director identified resident #1 and said she received a LNS for .

Review of the LNS records for resident #1 revealed a monthly LNS assessment was completed on and signed by staff F, a LPN.

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On at 4 pm, the health and wellness director confirmed the monthly assessment, which cannot be conducted by a LPN, was conducted and signed by staff F.

2. Observations made on at 12 pm revealed staff F, a nurse, applied a dressing to the of resident #1.

During an interview with the health and wellness director on at 4:15 pm, she said the of resident #1 was healed and she did not know why staff F placed a dressing to the area.

The record of resident #1 did not contain an order from a health care provider that authorized staff F to apply the dressing, which was a LNS.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on record reviews and interview, the facility failed to ensure nursing progress notes were maintained for 1 of 2 sampled residents who received Limited Nursing Services (LNS.) and did not maintain a monthly nursing assessment for 1 of 2 sampled LNS residents (#1).

Findings:

On at 10 AM, resident #2 was identified as receiving LNS for the application and removal of compression hose.

Record review revealed a telephone order dated time noted 7-3 for compression stocking to the right lower extremities (RLE) on in the AM and off at bed time. Compression stocking applied resident tolerating well.
The next note was dated and documented resident RLE applied, time 7-3.

Review of the medication observation record for revealed it noted apply compression stockings to RLE on am and off PM every morning and at bedtime. The Medication Observation Record (MOR) was initialed at 8 AM from through and at 8 PM on through and on at 8 PM the MOR was initialed with a code 9. According to the legend, the code 9 meant other/see nurse's notes.

Further record review revealed there were no other nursing process notes found in the record to

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document the application and removal of the compression hose.

On at 4 PM, the wellness care director confirmed the findings.

On at 10:30 am, the health and wellness director identified resident #1 and said she received a Limited Nursing Service (LNS) for .

Record review for resident #1 revealed an order from a health care provider, dated on , for 2 liters via nasal cannula as needed for .

Review of the LNS records for resident #1 revealed no documented evidence to indicate a monthly assessment was conducted for 2017, as required.

On at 4:45 pm, the health and wellness director confirmed the finding.

Class III

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

Based on the Agency's background Screening website and interview, the facility did not initiate all Criminal history checks through the clearinghouse before employment.

Findings:

Review of the facility's clearinghouse roster on at 2 PM revealed staff C, a caregiver hired and staff E the facility's Registered Nurse hired were not listed.

On at 4 PM, the business office manager confirmed the findings.

Unclassified

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on personnel record reviews, review of the online Agency background screening website, and interview, the facility failed to ensure 1 of 5 staff (E) who required a background screening, did not have any disqualifying offenses.

Findings:

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

The record did not contain the results of a level 2 background screening.

Review of the online Agency background screening website revealed staff E required a new screening.

On . . . . . at 4:25 pm, the business office manager confirmed the findings.

Unclassified