STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964130	**04/05/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE CLEARWATER**	STREET ADDRESS, CITY, STATE, ZIP CODE **2750 DREW STREET** **CLEARWATER, FL 33759**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2018001062 and CCR 2018002058) was conducted at Brookdale Clearwater Assisted Living Facility on . Brookdale Clearwater Assisted Living Facility had deficiencies at the time of the investigation.

(License #6670)

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

Based on interview and record review, the facility failed to notify a physician for a suspected change in condition and also failed to maintain a general awareness of residents' whereabouts for one (Resident #1) of four resident records sampled.

Findings included:

Interviews were conducted with the Health and Wellness Director at 11:24 AM and 3:07 PM on concerning resident elopements. The Director stated that Resident #1 was observed on the corner near the facility wearing pajamas and a bathrobe. They stated that nobody saw the resident leave the building, staff was not aware that they were gone, and they couldn't account for the resident's whereabouts between 9:00 AM and 11:40 AM (over two hours) on the day of the elopement ( ). They stated that staff are supposed to do rounds every 2 hours.

A review of Resident #1's records showed documentation dated that the resident was returned to the community by local police as they were found wandering outside approximately 2 blocks down the road with their walker, dressed with a blanket for a shawl, carrying a remote control from a TV, and a mobile phone cord.. It stated that the resident was unable to advise where they were going. A review of the website for accuweather.com showed that the high temperature for at the facility's location was 45 degrees.

A further review of Resident #1's records showed documentation dated . It stated that Resident #1 was on the evening shift. It stated that the resident told a resident care aide that they did not feel like living anymore and they weren't sure where they were. The entry ended with a notation to contact the medical doctor for a urinalysis (UA) in order to rule out the possibility of a ( ). A review of the record showed no order for a UA prior to . The record showed an

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964130	**04/05/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE CLEARWATER**	STREET ADDRESS, CITY, STATE, ZIP CODE **2750 DREW STREET** **CLEARWATER, FL 33759**	

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

entry dated indicating that the resident tested positive for a .

The Health and Wellness Director was interviewed again at 3:43 PM on concerning a doctor's order for a UA for Resident #1. The Health and Wellness reviewed Resident #1's record and stated that there was no UA before . They acknowledged that there was no proof that anyone contacted the resident's doctor prior to the elopement regarding a concern of a or a request for a doctor's order for a UA.

Class III

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

Based on observation and interview, the facility failed to maintain mechanical equipment in good working order to prevent residue from adhering to silverware and drinking glasses utilized by residents.

Findings included:

A tour of the facility was conducted, beginning at 9:37 AM on . The dining observed during the tour and the tables were set for the lunch meal with silverware and coffee cups. The tables in the dining small , , with numbers. Tables numbered 33, 34, 45 and 67 were observed with silverware, including spoons and knives, that contained white residue (photographic evidence obtained).

The Dining Services Director was interviewed at 9:55 AM on concerning observations of white residue on silverware on tables numbered 33. 33, 45, and 67. The Dining and Food Service director observed the silverware and acknowledged the residue present.

The Dining Services Director was interviewed in the dining at 1:35 PM on . There were observations of white spots on drinking glasses that were pointed out to the Dining Services Director (photographic evidence obtained). The Dining Services Director acknowledged the white spots on the glasses. When asked if there had been any issues with the dishwasher, they stated that the water softener did not seem to be working well.

Class III