STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964946	**06/05/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1765 WEST HIBISCUS BLVD** **MELBOURNE, FL 32901**	

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

0000 - Initial Comments

A complaint investigation #2018003488 was conducted on in conjunction to Complaint Investigation #2018003638 and revisit to Complaint Investigation #2018002438. Brookdale Melbourne license #9396 had a deficiency related to Complaint Investigation #2018003488.

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

Based on observations, record reviews and interviews the facility retained 2 of 5 sampled (#4 and #5), who exceeded assisted living facility residency criteria.

Findings:
1. Interview with staff A, who stated resident #5 resisted care, was scared of falling. A nurse was schedule to come today do his dressing changes to the on the hip. He added the resident had declined since his return from the hospital and was not able to assist with activities of daily living (ADLs) or transfer. He was . He would hit and fight the staff.

Observations on at 10 AM noted the resident was in bed and was . Said good morning. He was in a hospital bed, had a wheel chair nearby. There were 2 floor mats by the bed. Resident #4 sat in a wheel chair and spoke French. She had multiple in her legs. Staff A said the resident had declined recently and was unable to assist with her ADLs. She depended on the staff.

Observations on 6/5 at 10 30 AM during a home health nurse visit, resident #5 was in bed. Staff a came in to assist the home health nurse to remove the resident's adult brief, position resident and help hold the position so the nurse could do the care. The resident's Advanced Registered Nurse Practitioner (ARNP) come in to assess him as well. The ARNP and the home health nurse agreed the resident was no longer appropriate for assisted living because of his decline in ability to perform ADLS.

In an e-mail, dated from the resident's physical to the facility nurse indicated resident was being discharges as he reached maximum potential due to his difficulties. "Should the issues continue patient may end up requiring higher level of care than the facility could provide".

Resident record review for resident #5 revealed a health assessment report dated that indicated and open to . He needed assistance with all ADL except eating. According to the health assessment, he had a healing pressure to the right .

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Resident #4 had a health assessment report 1823 dated that listed and .
Supervision was needed with all ADLs and he needed assistance with toileting.

Facility notes dated:
Resident , also in and out of coherency. Medications reconciled with ARNP.
very agitated
/ agitated, punched staff
Mini-mental stated exam (MMES) dated resident scored 9 = 0-17 severe
Physical , note dated very , requires constant cuing

In an interview on at 3:30 pm with the administrator who said, she was not aware the resident had declined so quickly. Resident #4 usually required minimum assistance.

In an interview on at 3:30 PM with the Health and Wellness Director who said the staff was supposed to make her aware of the changes in the residents' condition.
2. Observation of resident #4 on revealed the resident seated in a wheelchair in the TV the memory care unit. She was leaning to the left slightly. At 1:15 PM Staff A came to assist the resident with toileting. He wheeled her to her , repeatedly asking her to lift her feet so he could move the wheelchair. Once in the , Staff A repeatedly instructed the resident to raise her arms and "give me a hug" but the resident was not responding, She was mumbling in French. He was finally able to get her arms up, and helped her stand. He asked her to turn her feet to sit on the toilet, but she did not do it. He turned her and lowered her to the toilet. After she was finished, he helped her stand and asked her to sit in the wheel chair. This time she did move her hands to hold onto the chair and the grab bar on the wall, stepped forward 2 steps, but did not turn. She started to sit and then stopped and said, "I can't." Staff A assisted her into the chair and brought her back to the TV .

On at 1:05 PM, Staff C stated they have to help resident #4 with just about everything now, "you know, like total care. She can feed herself though." She said they have to brush her , help her with transferring, toileting, bathing, everything.

On at 1:25 PM, Staff A stated he preferred to have resident #4 sleep in the chair rather than the bed because she tries to get up by herself and . He said her decline has "spiked quite a bit recently. We have to help her more and more."

Class III