STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965283	**06/07/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE VERO BEACH SOUTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **420 4TH COURT** **VERO BEACH, FL 32962**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2018003828, was conducted on and at Brookdale Vero Beach South, License # 9671. The facility had a deficiency at the time of the investigation.

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

Based on interview and record review, it was determined the facility failed to provide a safe and decent living environment, free from for all residents and to promptly investigate an allegation of per facility's policy and procedure, for 1 of 4 sampled residents reviewed (Resident #4).

The findings include:

During interview and record review conducted with the ED (Executive Director) and the HWD (Health and Wellness Director), on beginning at approximately 11:10 AM, they both acknowledged they did not conduct any investigation related to Staff D alleging that Staff E steps on Resident #4's toes to get him to stand up and do what she wants him to do and that Staff E also tells Resident #4 to shut up. The ED and HWD stated they were investigating a separate allegation and did not even realize this allegation was noted in the narrative of witness statements. The ED was asked for a copy of the facility's Reporting policy and procedure during entrance conference (at approximately 8:15 AM). She was not able to locate this requested Reporting policy and procedure during this inspection conducted on . The ED subsequently emailed this policy and procedure on . Review of this policy and procedure indicated the timing of the investigation should be initiated as soon as practicable upon becoming aware of an incident (allegation was made during another investigation initiated on). However, the ED and the HWD acknowledged an investigation related to this allegation of Staff E purposefully stepping on Resident #4's toes was not conducted as of the date of this inspection on . This policy also reflects there is to be a written record maintained of the investigation and the resident is to be protected during the investigation process and until a determination of the matter is pending. These components were not conducted. The facility was not able to provide any form of documentation indicating the facility implemented steps and procedures to ensure the safety of the residents upon being notified of possible on two different occassions involving the same staff , in which both staff members were identified. The facility failed to also ensure that the above staff members were the only , , and to determine if any other victims.

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Class III