STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964810	**06/25/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE CONWAY**	STREET ADDRESS, CITY, STATE, ZIP CODE **5501 EAST MICHIGAN STREET** **ORLANDO, FL 32822**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

The re-licensure survey with Limited Nursing Services (LNS) was conducted on . Brookdale Conway Assisted Living, license #9286, had deficiencies at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record reviews and interview, the facility admitted 1 of 5 sampled residents (#10) who exceeded the admission criteria for an Assisted Living Facility (ALF.)

Findings:

Resident #10's record revealed a facility admission date of . A most recent health assessment form 1823, dated on , was answered "yes" that she posed a danger to herself or others and that she required 24-hour nursing or , care. Additionally, the questions as to whether she was bedridden and whether her needs could be met in an ALF were not answered.

On at 2:30 p.m. nurse H confirmed the findings.

Class III

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure a health assessment (form 1823) was complete and accurate for 5 of 5 sampled residents (#4, #5, #6, #10 & #11).

Findings:

1. Review of the record for resident #4 revealed an admission date of . A review of the admission assessment form 1823, found the health care provider who signed the form did not date it.
2. Resident #5's record review revealed an incomplete 1823 Health Assessment not dated by the physician or healthcare provider.

3. Resident #6's record review revealed an incomplete 1823 Health Assessment not dated by the physician or healthcare provider.
4. Resident #11's record revealed a facility admission date of . The admission health assessment, dated on , did not contain documentation to indicate he had a ,

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however, a facility note dated on . . . . indicated he arrived to the facility with a . . . . . to his left heel.

A home health plan of care with a certification period of . . . . - . . . . indicated the onset date of the , was on , which was prior to the completion of his admission health assessment.

On at 2:26 p.m. nurse H confirmed the findings.

5. Resident #10's record revealed a facility admission date of . A most recent health assessment form 1823, dated on . . . . , revealed the questions as to whether she was bedridden and whether her needs could be met in an ALF were not answered. Additionally, page three of the health assessment was missing.

The record did not contain documentation elsewhere in the record to indicate a health care provider was contacted to obtain the omitted information.

On at 2:30 p.m. nurse H confirmed the findings.

Class III

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

Based on record reviews and interview, the facility failed to ensure 1 of 5 sampled residents (#10) who experienced a significant change had a face-to-face medical examination by a health care provider that was recorded on a health assessment form 1823.

Findings:

Resident #10's record revealed a facility admission date of . . . . . A most recent health assessment form 1823 was dated on . She was admitted to hospice services on .

Review of her record and hospice documents revealed neither one contained a new health assessment form 1823 when she was admitted to hospice, which was a significant change.

On . . . . . at 2:30 p.m. nurse H confirmed the findings and said the facility was waiting on hospice to provide a new 1823.

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Class III

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

Based on record reviews and interview, the facility failed to maintain a written record and failed to notify a health care provider and family when 1 of 5 sampled residents (#11) experienced an illness that resulted in a transfer to the hospital.

Findings:

Resident #11's record revealed a facility admission date of .

Documentation in his record, dated on , indicated he returned to the facility after discharge from the hospital. The record did not contain documentation to indicate why and when he was transferred to the hospital and no documentation to indicate a health care provider and family were notified of the transfer.

On at 2:26 p.m. nurse H said that on resident #11 said his left arm was numb and he had chest and back pain so the facility transferred him to the hospital. Nurse H confirmed his record did not contain the documentation and despite being provided the opportunity to do so, was unable to provide documentation that perhaps was located elsewhere.

Class III

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

Based on observations and interviews, the facility failed to post a copy of the Resident Bill of Rights or a summary provided by the Long-Term Care Ombudsman Program in full view in a freely accessible resident area and failed to maintain a clean and decent living environment.

Findings:

Observations made during a tour of the secured memory care unit on at 10:10 a.m. revealed an empty wheelchair was present in a day . The wheelchair contained dried food particles on the seat, on the armrests, on the wheels and on the frame.

On at 10:30 a.m. staff G confirmed the findings on the wheelchair and said the chair belonged to resident #12 who at the time was participating in a group exercise program.

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On at 11:30 a.m., the administrator said the facility did not have a routine cleaning schedule for the resident's wheelchairs but rather the chairs were cleaned as needed. He was unable to provide documentation to indicate the last time resident #12's wheelchair was cleaned.

On at 10:19 a.m. resident #10, who resided in the secured memory care unit, said she was never informed of her bill of rights.

On at 10:24 a.m. resident #9, who resided in the secured memory care unit, said he was never informed of his bill of rights.

Observations made along with staff G in each resident common area and in each hallway of the memory care unit on at 10:38 a.m. revealed a copy of the Resident Bill of Rights or a summary provided by the Long-Term Care Ombudsman Program was not posted in full view, as required.

Observations made on at 11 a.m. revealed a copy of the Resident Bill of Rights was posted on a wall to the right of the facility's main lobby. However, on at 11:15 a.m. the administrator said the posted Bill of Rights was not freely accessible for the residents who resided in the secured memory care unit.

Class III

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

Based on observations, record review and interview, the facility failed to make a daily effort to determine that 1 of 5 sampled residents (#10) who was at risk for elopement had Identification (ID) on their person that included their name and the facility's name, address and telephone number.

Findings:

Resident #10's record revealed an admission date of . A most recent health assessment form 1823, dated on , indicated she was at risk for elopement, getting lost, and wandering.

Observations made of resident #10 on at 2:15 p.m. revealed she did not have ID on either of her wrists or ankles and she said she did not have any form of ID on her person.

On at 2:25 p.m. staff G also checked the resident for an ID, confirmed the findings, and said she

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was unaware as to whether the resident ever had the required ID.

Resident #10's record did not contain documentation to indicate the facility made a daily effort to determine that she had ID on her person.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed staff (D) who assisted a resident (#10) with self-administered medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #10 on [redacted] at 10:30 a.m. revealed the resident stood by the medication cart. Unlicensed caregiver D unlocked the medication cart, removed a medication bottle from the cart, told the resident she was going to receive her [redacted], poured the pill into a medicine cup, then she handed the cup to the resident. Resident #10 took the pill with water and without assistance. Caregiver D observed the resident take the medication then she signed the Medication Observation Record (MOR.)

Caregiver D did not read the prescription label in the presence of the resident, as required.

On [redacted] at 10:35 a.m. caregiver D confirmed that she did not read the label in the presence of the resident.

Resident #10's most recent health assessment form 1823, dated on [redacted], indicated that she required assistance with self-administered medications.

Class III

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

Based on observations, review of a prescription label, record review and interview, the facility failed to ensure the Medication Observation Record (MOR) was accurate for 1 of 5 sampled residents (#10) who required assistance with self-administered medications.

Findings:

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Observations made during a medication pass for resident #10 on at 10:30 a.m. revealed caregiver D gave the resident a pill from a bottle in which the prescription label indicated the bottle contained 500 milligram (mg) tablets and the instructions for use were to take one tablet by mouth two times a day for two days then one tablet by mouth daily for three days. However, review of resident #10's 2018 MOR revealed the dose was listed as 600 mg.

On at 10:35 a.m. caregiver D said the prescribed dose of the was 500 mg, said the facility nurses updated the MORs, and said it was incorrectly transcribed onto the MOR.

Resident #10's most recent health assessment form 1823, dated on , indicated that she required assistance with self-administered medications.

Class III

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

Based on personnel record reviews and interviews, the facility failed to ensure 2 of 6 personnel records (A and E) contained documentation of a negative ( ) exam on an annual basis and failed to ensure 1 of 6 staff (E) submitted a written statement from a health care provider documenting freedom from communicable within 30 days after beginning employment.

Findings:

1. Caregiver A's personnel record revealed a hire date of . The record contained a negative exam dated on . However, the record did not contain a negative exam for 2018, as required.
2. Personnel record review for Staff E, the administrator, hired , revealed no documentation to confirm he was free from communicable and no documentation of a negative exam.

On at 1:10 p.m., the business office coordinator 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 (A, B, C and E) completed the 1 hour in-service trainings as required within 30 days of employment hire.

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Findings:

1. Staff C's personnel record review revealed date of hire and there was no documentation of the 1 hour in-service training for incident reporting.

On at 4 PM, an interview with the Business Office Manager who confirmed the finding.

2. Caregiver A's personnel record revealed a hire date of . The record did not contain documented evidence to indicate she received a minimum of 1 hour in-service training within 30 days of employment that covered reporting major and adverse incidents and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

On at 1:15 p.m., the business office coordinator confirmed the findings.

3. Personnel record review for staff B, caregiver/med tech (hired), did not reveal any documentation that she had completed training in Activities of Daily Living and Behavioral Needs, emergency preparedness & evacuation, incident reporting, or nutritional and safe food handling within 30 days of hire.

4. Personnel record review for staff E, the administrator (hired) did not reveal any documentation that she had completed training in the facility's policies and procedures regarding elopement response, or emergency preparedness & evacuation within 30 days of hire.

On at 1:20 PM the business office manager confirmed the findings.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on Personnel Record review and interview, the facility failed to ensure that 1 of 6 sampled staff (B) had obtained a one-time education course on and within 30 days of employment.

Findings:

Personnel record review for Staff B, hired , revealed no documentation to confirm she had completed the one-time education course on and .

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On . . . . . at 3:45 PM, the business office manager confirmed Staff B had not completed the training.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on personnel record review and interview, the facility failed to ensure that 2 of 5 unlicensed sampled staff (B and C) successfully completed the 4 hours initial medication training with self-administration of medications and 2 hours annual continued education in providing assistance with self-administered medications and safe medication practices in an assisted living facility as required.

Findings:

Staff C's personnel record review revealed date of hire was . . . . . and last two (2) hours annual update for medication training was documented on . . . . . . There was no certificate of completion for the 2 hours update medication training completed for the year 2017 and year 2018.

On . . . . . at 2:30 PM, an interview with acting Wellness & Health nurse (staff H) confirmed that staff C does assist with self-administration of medications to the residents.

In an interview with staff B on . at 2:25 PM, she stated she does assist with medications for the residents in the facility.

Personnel record review for Staff B, caregiver/med tech, hired . . . . . , revealed no documentation to confirm she had obtained the required 4 hour initial training in assisting with self-administration of medications.

On . . . . at 4:00 PM, the business office manager confirmed the findings.

Class III

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

Based on observation, personnel record reviews and interviews, the facility failed to ensure 1 of 3 direct care staff (A) received 4 hours of and Related (ADRD) continuing

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education annually and failed to ensure 2 of 6 staff (B and E) obtained 's level 1 training within three months of employment.

Findings:

Observations made on at 10:10 a.m. revealed the facility had a secured memory care unit.

1. Caregiver A's personnel record revealed a hire date of .

The record contained certificates of completion dated on for ADRD level 2 training, for one hour of ADRD training, and for one hour of ADRD training. The record did not contain documented evidence to indicate caregiver A received an additional three hours of ADRD continuing education during 2017 and 2018, as required.

On at 1:05 p.m. the business office coordinator confirmed the findings and despite being provided an opportunity to do so, was unable to provide additional ho
2. Personnel record review for Staff B, caregiver, (hired) did not reveal a certificate for training in Level I.

Personnel record review for Staff E, the administrator, (hired) did not reveal a certificate for training in Level I. The record did contain a certificate for Level II dated .

On at 3:05 PM, the administrator confirmed the finding.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record review and interview, the facility failed to ensure that all direct care staff were trained in the facility's policies and procedures related to ( ) for 1 of 6 sampled staff (E).

Findings:

Personnel record review for Staff E, the administrator, (hired) did not reveal a certificate for training in .

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In an interview with Staff E on at 3:05 PM, confirmed the finding.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record reviews and interview, the facility failed to ensure certificates of training contained the required information for 2 of 6 sampled staff (A and B).

Findings:

1. Caregiver A's personnel record revealed a hire date of . The record contained a certificate of completion for resident elopement however; the certificate did not contain the instructor's name, credentials, if applicable, signature, and location of the training, as required.

2. Personnel record review for Staff B, caregiver/med tech, hired , revealed certificates for training in the facility's policies and procedures for resident elopement and also for ( ) training, but neither certificate was signed or contained the name and credentials of the trainer, as required.

On at 1:20 PM, the business office manager confirmed the findings.

Class III

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

Based on personnel record review and interview, the facility failed to update and document 1 of 5 sampled staff (C) new job description as required for an assisted living facility with 17 and more residents.

Findings:

Staff C's personnel record review revealed date of hire as a resident care aide only assisting residents with Activities of Daily Living (ADLs). However, there was no updated job description reflect her new duties of assisting with self-administration of medication.

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On at 2:30 PM, an interview with acting Wellness & Health nurse (staff H) confirmed that staff C does assist with self-administration of medications to the residents.

On at 4 PM, an interview with the Business Office Manager confirmed the findings.

Class

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on personnel record reviews, review of the Agency's background screening website and interview, the facility failed to maintain the current results of a background screening in the personnel record for 1 of 6 staff (F) who were in a role that required a background screening.

Findings:

Nurse F's personnel record revealed a hire date of . The record did not contain the results of a background screening, as required.

On at 12:45 p.m., a review of the Agency's background screening website revealed nurse F had an eligible background screening on .

On at 1 p.m. the business office coordinator provided a copy of nurse F's background screening however, the form indicated the results were printed on . The business office coordinator confirmed the results of the screening were not in the personnel record at the time of the review.

Unclassified

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

Based on Agency Background Screening Clearinghouse review and interview, the facility failed to register and maintain the accurate employment status of employees within the Agency's Background Screening Clearinghouse for 1 of 6 sampled employees (F).

Findings:

Nurse F's personnel record revealed a hire date of .

Review of the Facility's Background Screening Roster did not reveal staff F listed as an employee.

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In an interview with the administrator on at 1 p.m., he confirmed the fining and stated he did not know she had to be on the roster since she was a corporate employee.

Unclassified

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

Based on personnel record review, Agency website review and interview, the facility failed to ensure that 1 of 2 sampled staff was in compliance with background screening requirements. (D)

Findings:

Personnel record review for Staff D (hired) had a background screen in her record with an eligibility date of .

Review of the Agency website on at 11:35 AM, revealed, "A new screening is required." The last screening for Staff D was over 5 years ago.

In an interview with the administrator on at 1:00 PM, he confirmed the findings and stated he was not aware this was overdue. The administrator was informed that staff D could not work until new screening results were obtained.

Unclassified