STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964946	R 07/24/2018
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

The revisit to complaint investigation #2018003488 was conducted on . . . . . Brookdale Melbourne, license #9396, had a deficiency at the time of the visit.

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

Based on observation, record review and interview, the facility failed to ensure the appropriateness of continued residency for 2 of 6 sampled residents (#1 & #4), and did not obtain a new health assessment after a significant change for 1 of 6 sampled residents (#14).

Findings:

1. Observations of resident #4 on found she was sitting in a chair in the memory care unit of the facility. Her walker was positioned in front of her. When greeted, she responded by speaking in French.

Review of her record revealed she was admitted to hospice services on . She was discharged from hospice on at her daughter's request. Continued review found the most recent health assessment (form 1823) was dated . . . . and included diagnoses of . . . . . and history of . The form noted she was and was a risk. She required assistance with self-administration of medications. The assessment documented that she required "supervision" with all Activities of Daily Living (ADLs), except she needed "assistance" with toileting. A new health assessment was not obtained as required at the start of hospice services. Further review found documentation of 8 between and , occurring on 6/7, , 617, , 7/6, , , and twice on . . . There were 8 incidents of aggression toward other residents and staff documented on , , , , 7/2, 710, , in the same time period.

Documentation of the on revealed she stood up and on the first step and hit her head. The note showed the daughter "would not let us send her to the hospital."
Documentation on showed notification of the ARNP for increased aggression by the resident toward staff and residents. The note documents the resident attempted to hit another resident, but this was prevented by staff intervention. On , documentation showed after several successful redirections by staff, resident #4 approached another resident in the dining threw a cup of water in her face. On resident #4 was documented as having verbally assaulted a new resident and used her walker to ram into/run over the new resident's feet while yelling. The activity director stood between the new resident and resident #4 to attempt to prevent injury to the resident.

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On at 1:40 PM, caregiver staff in the memory care unit stated, "She still is total care. We have been encouraging her to walk more with the walker but she continues to have ." When asked about resident #4's interactions with other residents, she lowered her head and said, "she goes after some of them. We try to redirect her and tell her 'no'." When asked if resident #4 could cause harm to other residents, the caregiver replied "Maybe. Probably."

On at 1:45 PM, a male caregiver reported resident #4 was "more angry lately and refusing care regularly."

As resident #4 was previously cited by the Agency as inappropriate for residing in an assisted living on , the facility did attempt to provide hospice services for the resident.

On at 3:45 PM, the administrator confirmed when the hospice services were discontinued by the family, the facility failed to issue a 45 day notice of discharge and retained the resident who exceeded the residency requirements for an assisted living facility and was exhibiting behaviors that posed a danger to herself and others.

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2. On at 10:27 a.m. caregiver A said resident #1 required total assistance with his Activities of Daily Living (ADLs) and transferring.

Resident #1's record revealed a facility admission date of . An 1823 health assessment form, dated on , indicated that his diagnoses included muscle wasting and Atrophy, abnormalities of his gait and mobility, Parkinson's , , , , Spinal , Type 2 , and an open on his right .

A health care provider's visit note, dated on , indicated that he was no longer appropriate for an Assisted Living Facility and he required 24-hour continuous skilled nursing. The note also indicated the facility's nursing staff reported that he required total care and the assistance of two people for repositioning and transferring and observations made during the visit revealed he was fearful of falling while turning in the bed and required 2-person . At that time, the on his right hip was described by the provider as a , that contained a moderate amount of yellow and drainage and the plan was to start 500 milligrams by mouth every 6 hours for 10 days.

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A home health registered nurse recertification note, dated on , indicated that he depended entirely upon another person to dress his lower and upper body, he was totally dependent in toileting, he was unable to transfer himself and was unable to bear weight or pivot when transferred by another person.

Observations made of resident #1 being transferred from his wheelchair to the toilet by caregivers J and I on at 1:30 p.m. revealed he was immediately argumentative with the caregivers and resistive to care. Caregiver J placed his arms under each of the resident's arms and caregiver I grabbed hold of the back of his pants then they lifted him to a standing position. Caregiver J held him in that position while caregiver I lowered his pants then caregiver J sat him on the toilet. During the transfer, the resident yelled out that the caregivers were trying to kill him and he would not stand straight up but rather kept his knees bent and buckled while leaning his body against caregiver J. Caregiver I provided him with total toileting care and at the conclusion, caregivers J and I repeated the process of transferring him from the toilet to his wheelchair. The resident did not pivot during the transfer but rather caregiver J lifted him and turned his body to the desired position.

Review of facility notes revealed that on the facility spoke with his family regarding transferring him to a higher level of care. He was placed on the waiting list of a skilled nursing facility that the family chose.

On another resident tried to get resident #1's attention by tapping him on his shoulder and he turned around and smacked the resident in the face. The facility left a message for resident #1's family to ask about the plan for his transfer to another facility.

On the facility left a message for his family to check the status of placing him in a skilled nursing facility.

On the facility received a list of options of alternative placement facilities from his family. The facility contacted some of the facilities but many did not have an open bed. A referral was faxed to another facility.

On he was lowered to the floor while in the .

On his family told the facility that a Medicaid case manager instructed her to move him to another Assisted Living Facility rather than a Skilled Nursing Facility. A representative from another Assisted Living Facility came to the facility to evaluate him for placement. His record did not contain documentation to indicate whether the facility accepted him or not and no documentation to indicate the

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facility contacted them to follow up on their evaluation.

On he was accepted by a Skilled Nursing Facility however, his family declined the acceptance and said the facility was too far.

On at 4 p.m. the administrator said the facility did not issue a 45-day notice of discharge when the health care provider indicated on that the resident was no longer appropriate to remain in the facility.

3. Record review for resident #14 revealed she was admitted to hospice services on . Further record review revealed there was no updated resident health assessment form 1823 for the hospice admission available for review. The latest 1823 form in the record was dated .

On at 3 PM, the Licensed Practical Nurse confirmed the findings.

Class III