STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964204	07/23/2018
NAME OF PROVIDER OR SUPPLIER **BROOKDALE EAU GALLIE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2680 CROTON ROAD** **MELBOURNE, FL 32935**	

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

0000 - Initial Comments

The re-licensure survey with Limited Nursing Services was conducted on . . . . . Brookdale Eau Gallie Assisted Living, license #8885, had deficiencies at the time of the visit.

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

Based on record reviews and interviews, the facility failed to ensure the 1823 health assessment form was complete and accurate for 4 of 4 sampled residents (#3, 5, 10 and 13.)

Findings:

1. Resident #10's record contained a facility admission date of . . . . and a most recent 1823 health assessment form that was erroneously dated on . In addition, the sections on the form regarding how much assistance she required for transfers, whether she required assistance with her medications and the examiner's medical license and address were either not answered or left blank.

On at 3:30 p.m., the health and wellness director was provided an opportunity to produce the omitted information but she said the information was not documented elsewhere.

2. Resident #5's record contained a facility admission date of . . . . and a most recent 1823 health assessment form that was dated on . The form indicated she required assistance with her medications however, it did not indicate how much assistance was required. In addition, the form did not contain an address for the examiner, as required.

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

On . . at 5:09 p.m., the health and wellness director confirmed the findings.

3. Resident #13's record contained a facility admission date of . . . . and a most recent 1823 health assessment form that was dated on . The question on the form that pertained to whether she required assistance with her medications was not answered and the record did not contain documentation to indicate the facility contacted a health care provider to obtain the omitted information.

On at 5:15 p.m., the health and wellness director confirmed the findings.

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4. Review of the record for resident #3, admitted on [redacted], found a health assessment dated "[redacted]." There was no year indicated on the form by the provider who signed it.

On [redacted] at 5:00 PM, the health and wellness director confirmed the finding.

Class III

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

Based on record review and interview the facility failed to obtain a Completed Resident Health Assessment (AHCA form 1823) after a significant change (hospital admission and [redacted]) for 2 of 7 sampled residents (#7 and #10).

Findings:

1. Review of the progress note revealed resident #7 was admitted nto the hospital on [redacted] and returned on [redacted]. Record review for resident #7 revealed there was no updated AHCA form 1823 completed after the hospital admission.

On [redacted] at 4 PM, the wellness director confirmed the findings.

2. Resident #10's record contained a facility admission date of [redacted] and documentation that indicated the presence of a [redacted] on her left [redacted] and an unstageable [redacted] on her left ankle. She was admitted to Hospice services on [redacted]. The record contained two 1823 health assessment forms, one was dated on [redacted] and the other was erroneously dated on [redacted].

On [redacted] at 5:29 p.m., the health and wellness director provided documentation that indicated both [redacted] developed on [redacted] and said a new 1823 health assessment form was not completed when the [redacted] developed, as was required for a significant change.

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 follow an order from a health care provider for 1 of 4 sampled residents (#9) who required assistance with self-administered medications.

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Findings:

Resident #9's record revealed a facility admission date of . A most recent 1823 health assessment form, dated on , indicated that he required assistance with self-administered medications. An order from a health care provider, dated on , indicated he was to receive 2.5 milligram (mg)/3 milliliters (ml,) 3 ml via three times a day.

Review of his , 2018 Medication Observation Record (MOR) revealed that on at 8 p.m. and on at 8 a.m. "09" was documented in the boxes reserved for staff to indicate the medication was given.

On at 5:08 p.m. the health and wellness director said the "09" meant the medication was not given and was unavailable however, she said the medication was available at that time but the staff did not look in the over flow box where additional doses of the medication were located.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256(3-4); 58A-5.0185 (3)

Based on observations, record reviews and interview the facility failed to ensure the unlicensed staff (A) who assisted a resident (#1) with self-administered medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #1 on at 10:05 a.m. revealed the resident stood next to the medication cart. Caregiver A unlocked the cart and after removing each medication package, told the resident the name of the medication and the reason for its use and then she poured each medication into a medicine cup. She removed a tablet from the cup, crushed it, and then she poured it back into the cup of pills. She placed applesauce into the cup and mixed the sauce with the pills. Using a spoon, she scooped the mixture into the resident's mouth. The caregiver signed the Medication Observation Record (MOR) and it was at that time that she noticed some of the medication entries were a "pink" color, which indicated those medications, had not been signed as given. She said she did not realize they had to be given when she gave the first set of medications. She then removed additional packages from the cart, told resident #1 the name and reason for each medication, popped each medication into a cup, mixed the medications with apple sauce, then she used a spoon to scoop the mixture into the resident's mouth.

Caregiver A did not read the medication labels aloud to the resident, as required.

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On at 1 p.m., caregiver A confirmed the findings.

Resident #1 was admitted to the facility on . His current health assessment (form 1823) was dated and documented he required assistance with the self-administration of medications.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, review of the Medication Observation Record (MOR) and interview, the facility failed to ensure that medications were ordered in a timely manner for 5 of 8 sampled residents (#3, #5, #6 & 7).

Findings:

1. Review of the 2018 electronic MOR for resident #3, found the code "09, see nurses' notes" documented on 7/9, , and for , Solution 0.005%; instill 1 drop in both eyes one time a day for .

On at 4:45 PM, the Wellness Director stated code "09" was used when there was no medication available to give. She confirmed the MOR showed code 09 documented on several non-consecutive dates. She further confirmed the medication was out of stock and was not given as ordered, and that it appeared the staff documented it was given even when there was no medication to give.
2. Resident #5's record revealed a facility admission date of and a most recent 1823 health assessment form, dated on that indicated she required assistance with her medications.

Review of her 2018 Medication Observations Record (MOR) revealed an entry for 20 milligram (mg) tablet, give 1 tablet by mouth daily. On and , "09" was documented in the boxes reserved for staff to indicate whether a medication was given and the resident's progress notes indicated the medication was not available.

Resident #5's 2018 MOR contained an entry for , 25 mg tablet, give 1/2 tablet by mouth twice daily. On at 5 p.m., "09" was documented and the progress note indicated the medication was not given.

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On at 5:09 p.m., the health and wellness director confirmed the findings and said the caregivers were waiting on the nurse to obtain the medication refills.

3. On at 10:30 AM, resident #6 said she received assistance with the self-administration of her medications she was out one of her inhalers. She did not know why.

Review of the Electronic Medication Observation Record (MOR) for resident #6 revealed for some days there were staff initials in the spaces and a "9" some examples are as follows:
For Tablet 70 Milligrams (MG) one time every Sunday for bones on 7/1, 7/8, and .
600 give 3 one time a day for gummies on 7/2, 7/5, 7/8, through , through , through .
solution 6.5.% Instill 5 drops in left ear two times a day for ear wax at 0800 and 1700 on 7/1 through 7/3; at 0800 on 7/5, 7/7 through 7/9; through ; through ; through
At 1700 on 7/6, 7/8, 7/9, , , and .
, Handihaler capsule 18 Micrograms 2 inhalation inhale orally one time a day for at 0800 on .
The legend on the Electronic MOR noted "9" meant=other/see nurse notes.
Review of the nurse's notes indicated the medications were not available because they were waiting on orders.
Staff A said on at 11:45 AM (after reviewing the electronic MOR for her initials found) that the "9" meant the medication was not available to give to the resident when she was assisting the resident's with their medications. She said the inhaler , Handihaler was not available for the resident this morning and she initialed the Electronic MOR and placed a 9 in the space.

4. On at 10 AM, resident #7 said received assistance with the self-administration of her medications she was out of her , ; she said the staff told her they were waiting on the medication.
Review of the Electronic Medication Observation Record (MOR) for resident #7 revealed for some days there were staff initials in the spaces and a "9" some examples are as follows:
For , tablet 25 MG one two times a day for at 0800 on through at 1700 on through .
15 mg one daily for pain at 0800 on through
The legend on the Electronic MOR noted "9" meant=other/see nurse notes.
Review of the nurse's notes revealed the medications were not available because they were waiting on orders.

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Staff A said on at 11:45 AM (after reviewing the electronic MOR for her initials found) that the "9" meant the medication was not available to give to the resident when she was assisting the resident's with their medications. She confirmed both of the resident's medication , and were not available on .

On at 5 PM, the wellness director said the staff were, faxing the resident health assessment form 1823 to the pharmacy for refills and they later found out the pharmacy was not accepting the resident health assessment for 1823, but needed a prescription from the health care provider before refilling.

Class III

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

Based on observations, record reviews and interview the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience by allowing unlicensed staff (A) to administer medications to 1 of 13 sampled residents (#1) and to titrate the flow of for 1 of 13 sampled residents (#1.)

Findings:

Observations made during a medication pass for resident #1 on at 10:05 a.m. revealed the resident stood next to the medication cart. Caregiver A unlocked the cart and after removing each medication package, told the resident the name of the medication and the reason for its use and then she poured each medication into a medicine cup. She removed a tablet from the cup, crushed it, and then she poured it back into the cup of pills. She placed applesauce into the cup and mixed the sauce with the pills. Using a spoon, she scooped the mixture into the resident's mouth. The caregiver signed the Medication Observation Record (MOR) and it was at that time that she noticed some of the medication entries were a "pink" color, which indicated those medications, had not yet been signed as given. She said she did not realize they had to be given when she gave the first set of medications. She then removed additional packages from the cart, told resident #1 the name and reason for each medication, popped each medication into a cup, mixed the medications with apple sauce, then she used a spoon to scoop the mixture into the resident's mouth.

When caregiver A spooned the medications into resident #1's mouth, she administered the medications which was a task unlicensed staff were not permitted to do.

During an interview with caregiver A on at 12:44 p.m. she identified resident #2 as receiving

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and said she assisted the resident with her by changing her over from the concentrator to a portable tank, by turning on the tank, then by titrating the flow to 3 liters per minute, which she believed was the prescribed amount. In addition, she said the resident also provided her with instructions on what to do.

When caregiver A titrated the flow for resident #2, she performed a task that unlicensed staff were not permitted to do.

On at 1 p.m., caregiver A confirmed the findings.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 5 sampled staff (D) received the required in-service training within 30 days of hire.

Finding:

Personnel Record review for Staff D (administrator, hired , 2015), revealed no certificate documenting training in the facility's policies and procedures regarding emergency preparedness and evacuation training including chain of command.

On at 4:30 PM, the administrator confirmed the findings.

Class III

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

Based on observation and interview, the facility failed to maintain a clean living environment pursuant to Section 429.28 (1) (a) Florida Statutes.

Findings:

Observations during the tour of the facility on revealed dirty and stained carpeting throughout the common areas of the facility. All 3 resident hallways had numerous dark stains. The common area outside the elevators on the second floor also had multiple stained areas.

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In an interview with the administrator on at 5:00 PM, she stated they were trying to clean the carpets regularly, but the stains do not come out.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observations, record reviews and interview, the facility failed to ensure that the resident record for 1 of 4 sampled residents (#9) contained an order from a health care provider to self-administer a medication.

Findings:

Observations made on at 11:14 a.m. revealed the presence of vials and syringes in resident #9's . He said he self-administered his .

Resident #9's record revealed a most recent 1823 health assessment form, dated on , that indicated he required assistance with self-administered medications. Each entry on his , 2018 Medication Observation Record (MOR) indicated "unsupervised self-administration" (U-SA.) However, his record did not contain an order from a health care provider to indicate he was able to self-administer his .

On at 5 p.m., the health and wellness director confirmed the findings.

Class III

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

Based on Agency Clearinghouse Website Review and Interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 1 of 5 sampled staff (E).

Findings:

Review of the Agency's Background Screening website for 5 sampled staff revealed that Staff E, LNS nurse, was not on the clearinghouse roster for the facility.

In an interview with the administrator on at 4:30 PM, she confirmed Staff E was not on the

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roster.

Unclassified