STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965048	**07/30/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE OVIEDO**	STREET ADDRESS, CITY, STATE, ZIP CODE **1725 PINE BARK** **OVIEDO, FL 32765**	

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

0000 - Initial Comments

Relicensure survey including Limited Nursing Services was conducted on . Brookdale Oviedo Assisted Living Facility, License #9525, had deficient practice identified during the survey.

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 an 1823 health assessment form was complete for 1 of 3 sampled residents (#13).

Findings:

Resident #13's record revealed a facility admission date of . The record contained an 1823 health assessment form that was not dated and did not contain the address of the examiner.

On at 2:43 p.m., the health and wellness director confirmed the finding, and said she believed the 1823 was completed on when the resident had a hospital stay.

Class

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 3 sampled residents, 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 (#13).

Findings:

Resident #13's record revealed a facility admission date of and a hospice admission date of . The record contained an 1823 health assessment form that was dated on and one that was not dated.

On at 2:43 p.m., the health and wellness director said she believed the undated 1823 was completed on when the resident had a hospital stay.

On at 3:20 p.m., the health and wellness director said a new 1823 was not completed when resident #13 was admitted to hospice services, which was a significant change.

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Class III

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

Based on observations, record reviews and interview, the facility failed to provide adequate supervision and interventions when a resident (#13) experienced multiple .

Findings:

Observations made of resident #13 on at 10:15 a.m. revealed she was sitting at a table in a high back wheelchair. She had a on her right eye and an on her right forehead. She was sliding down in the wheelchair and two staff members lifted her back up.

Resident #13's record revealed the following:

A facility admission date of . An admission 1823 health assessment form, dated , indicated she was at risk for .

1. Documentation in the record indicated that on she had an unwitnessed outside on the side walk. She had left eye with and a small laceration. 911 was called and she was sent to the emergency . On , she returned from the hospital.

2. On , she had an unwitnessed in the parking lot. She was unresponsive with minimal to the left side of her temple. 911 was called and she was transported to the emergency returned to the facility on the same day. On , her and were discontinued due to her unsteady gait. On , she was moved to the facility's memory care unit.

3. On , she had an unwitnessed by her . She said she bumped her glasses against the wall which caused her to have two small to her left eyebrow.

4. On , she had an unwitnessed . She was observed lying in a supine position on the . She said she was ambulating with her walker to the she lost her balance and . A small hematoma was noted to the back of her head. On , physical was ordered to evaluate and treat for and an unsteady gait.

5. On , she was admitted to hospice services. On , she had an unwitnessed . She

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said she was ambulating without her walker from the bed to her recliner when she lost her balance and . .

6. On . . . . , she had an unwitnessed in front of her . . . . . . She was unable to recall how she .

7. On , she was observed lying on the floor behind her wheelchair.

8. On at 4:15 p.m., a thud was heard followed by yelling. She was observed on the floor in the hallway. She said she struck her head and complained of a . . . . . .

9. On . . at 8:15 p.m., she was observed on the floor in the . . . . . , and complained of pain to her head. She was sent to the hospital. Results of a computed tomography (CT) scan of her head/ without contrast, dated . . . . . , indicated there was a significantly larger left frontotemporoparietal hematoma. There was effect and a midline shift and a persistent although significantly improved small mixed density right-sided frontoparietal . . . . . hematoma.

10. On . . . . . , she was observed on the floor lying on her back. Another resident reported that this resident stood up from her wheelchair and back. She had scratches and red areas to her face above her left eyebrow, under her left eye, on the bridge of her nose and above the left side of her lip.

11. On . . . . . , she had an unwitnessed by her . . . . She could not recall how she . .

12. On . . . . . , she had an unwitnessed by her . . . . She sustained a . . . . on her left upper arm and she complained of moderate pain on her left lower back. A health care provider ordered a chest X-ray due to left pain. Results of a X-ray, dated . . . . . , revealed she had acute . . . . . of her 8th and 9th ribs on the left side. On a high back wheelchair with a cushion was ordered.

13. On , she had an unwitnessed . She could not recall how she . The staff would continue to monitor her.

14. On . . . . . , she was found on the floor in front of her bed. . . . . 5 milligrams (mg.) by mouth every bedtime was ordered. An incident report indicated the staff would increase the frequency of monitoring her.

15. On . . . . . , she was found on the floor. , . . . , ... 10 mg. by mouth at bedtime and during the day as needed for , was ordered. An incident report indicated the staff would increase the

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frequency of monitoring her. On , hospice ordered to keep floor mats by her bed with her bed in low position.

16. On , she was observed on the floor in front of her bed. She was from a laceration on her right eyebrow. She was sent to the hospital for an evaluation and returned to the facility on the same day. On , a hospital bed was delivered.

Based on the facility's documentation, resident #13 experienced 16 between 2017 and , 2018, and on two separate occasions, she sustained a hematoma and .

On at 1:30 p.m., the health and wellness director confirmed the findings. An opportunity was provided for her to provide additional documented evidence to indicate the facility implemented additional interventions following the resident's . At 2:15 p.m., the health and wellness director said the facility had no additional documentation to provide.

Class II

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

Based on observations, review of medication containers, record review and interview, the facility failed to ensure a medication container was properly labeled for a resident who received assistance with self-administered medications (#9).

Findings:

Observations made during a medication pass for resident #9 on at 9:35 a.m. revealed unlicensed caregiver F gave the resident one 1 milligram (mg.) tablet. The prescription label on the medication package indicated one tablet was to be taken daily. However, resident #9's , 2018 Medication Observation Record (MOR) indicated the medication was to be taken twice a day. The medication package did not contain an alert label to direct staff to examine the revised directions for use in the MOR, as required.

On at 9:50 a.m., caregiver F said the frequency on the MOR was the most recent order and confirmed the medication package did not contain an alert label.

Resident #9's record contained a most recent 1823 health assessment form, dated , that indicated she required assistance with self-administered medications. In addition, the record contained

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an order from a health care provider, dated , to discontinue the 1 mg. daily and give 1 mg. twice a day.

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 (F) to make a judgement or discretion as to whether a medication would be given to a resident (#9) who received assistance with self-administered medications.

Findings:

Observations made during a medication pass for resident #9 on at 9:35 a.m. revealed unlicensed caregiver F sanitized her hands, compared the prescription labels to the Medication Observation Record (MOR), took the medication packages to the resident in her , read the labels to the resident then she popped each pill into a medicine cup in the resident's presence. Using an electronic wrist cuff, caregiver F attempted to check the resident's , three times however; she received an error message on the device after each attempt. She called for a nurse to assist her. Nurse G entered the , checked the resident's , and obtained a reading of . Without discussing the reading with the caregiver as it related to her medications, nurse G exited the . Caregiver F said she was not going to give the resident her , because her , was too low then she handed the cup of pills to the resident, who took them without assistance. Caregiver F observed the resident take the medication then she returned to the medication cart and signed the MOR.

On at 9:45 a.m., caregiver F confirmed that she alone made the decision to hold the resident's , "a decision that only a licensed nurse could make" based on the , reading.

Resident #9's record contained an 1823 health assessment form, dated , that indicated she required assistance with self-administered medications. Her list of diagnoses included , .

An admission 1823 health assessment form, dated , contained a health care provider's order for , 5 milligrams by mouth daily, hold if , was less than .

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Class III

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

Based on record reviews and interview, the facility failed to ensure the consent form for unlicensed staff to assist residents with self-administered medications was complete for 1 of 3 sampled residents (#13).

Findings:

On at 9:30 a.m., the health and wellness director said the facility utilized unlicensed staff to assist residents with self-administered medications.

Resident #13's record contained an 1823 health assessment form, dated , that indicated she required assistance with self-administered medications. In addition, the record contained a consent form for unlicensed staff to assist with self-administered medications. However, the form did not indicate whether the unlicensed staff would or would not be overseen by a licensed nurse, as required.

On at 2:42 p.m., the business office manager confirmed the finding.

Class

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on resident record review and interview, the facility failed to ensure that 1 of 2 sampled residents' provision was included in the contract agreement that an AHCA 1823 Health Assessment form must be updated every 3 years and or at significant change as required in subsection 58A-5.0181(2) Florida Administrative Codes (#7).

Findings:

Resident #7's resident record review revealed an executed contract signed on but did not include documentation of the provision that an 1823 Health Assessment must be completed every 3 years and/or at a significant change.

On at 2 PM, the Business Office Manager confirmed the finding.

Class

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

Based on the observations, interview and the agency's background screening website, the facility did not initiate all Criminal history checks through the Agency for Health Care Administration's (AHCA) Clearinghouse before employment (C & D).

Findings:

1. Review of the current staff schedule revealed staff C was listed and was employee more than 10 days. Review of AHCA's background screening website on at 2:30 PM revealed staff C was listed on the roster with a hire date of and a end/termination date of .

2. On at 2 PM, the business office manage said staff D had been the interim administrator since .

Review of AHCA's background screening website on at 2:30 PM revealed staff D was not listed on the roster.

On at 3 PM, the business office manager confirmed the findings.

Unclassified