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	AL11965424	**10/16/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE LAKE ORIENTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **217 BOSTON AVENUE** **ALTAMONTE SPRINGS, FL 32701**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A Change of Ownership (CHOW) survey with Limited Nursing Services (LNS) was conducted on . Brookdale Lake Orienta, License #9795, 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 12 sampled residents who exceeded the admission criteria for an Assisted Living Facility (ALF) (#5).

Findings:

Resident #5's record revealed a facility admission date of . His admission 1823 health assessment form, dated , indicated that he posed a danger to himself or others, which exceeded the admission criteria to an ALF.

On at 3:45 p.m., the director of nursing confirmed the finding and was unable to provide additional documentation.

Class III

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

Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents who experienced a significant change had a -to- medical examination by a health care provider that was recorded on a health assessment form 1823 (#7), and retained a resident who exceeded the continued residency criteria in an Assisted Living Facility (ALF) (#5).

Findings:

1. Resident #5's record revealed a facility admission date of . His admission 1823 health assessment form, dated , indicated that he posed a danger to himself or others. He had a diagnoses of .

Facility notes indicated that on he seemed depressed and mentioned putting a gun to his by pointing a to his . A health care provider was notified.

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On , he followed another resident into a room. He was not invited into the room and he forced his arm into the crack of the door before being closed. He got upset. He attempted to push the door open. He grabbed the resident by her left and started to shake her. An attempt was made to stop him from grabbing the other resident and he began punching and hitting staff.

On at 8 a.m., he was violent towards staff and other residents. He approached a table during breakfast and banged the table, sending food everywhere. Other residents were seated at the table. He punched and spit on the facility driver and began to fight residents.

On at 8:30 a.m., he became aggressive and yelled at other residents. He approached the facility's driver, punched the driver several times, kicked the driver, then spit in his . Staff attempted to calm him down but he continued to be aggressive. 911 was called. He the law enforcement who responded to the facility.

On at 3:45 p.m., the director of nursing said he was taken to the hospital on and was returned to the facility.

On at 6:40 p.m., yelling and screaming was heard. He had taken the walker of another resident and threw it across the living room. The staff were able to calm him. He wanted to speak with his wife. While a staff member was on the phone, he snatched the phone from the staff and attempted to strike the staff member with the phone. He was restrained until the police arrived.

On at 3 p.m., the memory care director said when the police arrived to the facility on , they were able to calm him down.

On at 2 p.m., he was aggressive to another resident.

On at 3:30 p.m., he became very combative with staff, family and another resident.

On at 2 p.m., he was aggressive towards staff and another resident.

On at 9:30 a.m., he became very combative with staff and another resident.

On at 3 p.m., he made the resident in very uncomfortable. When the staff tried to remove the resident from him, he became very aggressive and tried to the staff.

On at 1:30 a.m., he was observed in . He was redirected to come out then he became

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aggressive and combative with staff. He calmed down after minutes.

On at 2 p.m., a visitor reported that he said, "The only way to get out is to kill myself." A health care provider was notified.

On at 8:30 p.m., he became aggressive with another resident and when the resident who resided in apartment 119 tried to stop him, he tried to hit the resident, was grabbed by the other resident and he sustained a .

On at 10:34 p.m., he was in other resident's room and he had an altercation with another resident.

On at 7:30 p.m., he became aggressive towards another resident and attempted to enter that resident's apartment.

On at 3:18 p.m., he became aggressive towards the wife of another resident.

Resident #5 was identified, prior to his admission to the facility, as posing a danger to himself or others and facility notes indicated that on multiple occasions he was aggressive towards other residents however, the facility retained him which placed the other residents at risk for harm.

On at 3:45 p.m. the director of nursing confirmed the findings.

2. Record review for resident #7 revealed he was admitted into the facility on . The resident health assessment (AHCA form 1823), dated , noted the resident did not have any , 3 or 4 .
Review of the facility's personal service plan-dated revealed it noted, " care for one is provided by health care."

Review of the home Health agency's record reports provided by the facility revealed on it noted an to the right heal with measurements of 2 centimeters (cm.) by 2 cm. by 0.1 cm. The was restaged on .
Further review of the record revealed the following measurements that did not show improvement:
the measured 2 cm. by 1.5 cm. by 0.1 cm.
the measured 2.8 cm. by 3.5 cm. by 0.3 cm.
the measured 3 c,. by 3.5 cm. by 0.3cm.

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The facility admitted the resident with an which exceeded residency criteria for an Assisted Living Facility.

Review of the hospice record revealed the resident was admitted to hospice services on and the last assesment form (1823) available for review was dated . There was no assessment form completed after the significant change when the resident was admitted to hospice.

On at 3 PM, the wellness director confirmed the findings.

Class II

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

Based on observation, resident record review and interview, the facility did not provide care and services appropriate to meet the needs to ensure the safety through proactive measures to minimize the potential for and injuries for 1 of 3 sampled residents at risk for (#7), did not maintain a written record that the health care provider and family was contacted of significant changes, which resulted in medical attention and behaviors changes for 1 of 3 sampled resident (#7), and did not document for 1 of 3 sampled residents that the family and health care provider was contacted when he sustained a to the due to an event that occurred with a facility employee (#5).

Findings:

1. On at 9:45 AM in the secured memory care unit, resident #7 sat in a high wheelchair in the day room. He had a purple circular on his forehead.

Resident #7's record revealed a health assessment form (1823), dated , that noted the resident had and a , on , and special precautions as " Risk".

Resident #7 was admitted to the facility on and had the following since admission, some with injuries:
at 5 AM - at 4:15 AM staff (co-worker) observed resident lying down on the floor beside his bed on his left side with a small scrape on his right .
at 4 PM - resident's right was and resident continuously said "ow". 911 was called to evaluate , and family refused sending resident out.
at 9 PM - resident had a . Slipped to the ground from wheelchair. 911 called for assistance. No signs and symptoms of injury noted at the time. Family was notified.

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at 10 PM - resident had two , one witnessed and one at 10 PM. No signs and symptoms of injury. Resident helped backed into chair at 5 PM by staff and at 10 PM, 911 was called for assistance.

at 6:30 PM - resident flipped tables and chairs over and in the process, he received a on his left . First aid was applied.

at approximately 1:45 AM - resident was found in knelling position next to his bed, both were red and had a . Family and health care provider was notified.

at 7:30 PM - resident found on the ground near door by resident associate, 911 was called to assist in lifting resident. Unknown if resident hit . Resident's family was notified and she denied sending resident out. Resident awake and alert, able to move all extremities. No signs and symptoms of injury noted.

at 4 PM -"Resident wife complained about her husband cannot move the left . I was calling the doctor to notify."

at 5 PM - "resident wife said he slide in the chair."

at 3:30 AM - at 3 AM observed resident lying down on the floor beside bed with scrape on right and left . He denied , . Wife was notified.

-5 AM - at 4:15 AM, Resident Assistant observed resident lying down on the floor bedside his bed. No apparent injury. Wife was notified.

- resident came to FL hospital accompanied by paramedic. Resident alert and stable.

- "Resident agitated tonight, resident was sleeping on chair, associates attempted to take resident to bed. Resident resisted, associate let him calm down, resident tried to get up from chair and slide down to bottom on floor, no injury noted."

at 1:13 AM - "resident was found on the floor during check and change 0 injury noted. EMT was called to lift him from the floor. Wife and health care provider notified, will continue to monitor.

- "Resident was very agitated today. He kept on standing up in his wheelchair when they put him at the table to eat. He took the table cloth and tried to slam across the other residents, he also scratch (name of staff noted) the Certified Nursing Assistant (CNA) when she tried to help him out, he refused to eat dinner. He did take his meds after several tries, when the night shift came they tried to put him in bed he one of the CNA. F inally he went to bed but he did give them a hard time to change his brief."

at 5 AM - "observed resident lying down flat on his on the floor, beside his bed. No apparent injury. Could not say what happen. Wife and health care provider notified. Will continue to monitor."

- "Resident is combative at times and also refused to take meds at times."

at11 PM - resident was very agitated and kept standing in the chair. About 9 AM, resident found on the ground by his son. 911 was called. He refused to take vital signs, I send him to the hospital for evaluation. Wife notified."

- "resident slip off his couch, wife was with him when it happen. She notified nurse 911 was

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called to get him off the floor. No injury noted resident is alert and oriented."
at 6 PM - "resident alert and responsive. Resident admit to Vitas hospice."
at 1:30 AM - "observed resident lying down on is right side on the floor beside his bed. No apparent injury. Wife and doctor notified. will continue to monitor."
at 2 AM - at 1:10 AM "observed resident lying down on his on the floor beside his bed. Have small and some on his forehead. Sent out to hospital notified wife and doctor."
at 5:30 AM - resident arrived via special transport from hospital @ 5:15 AM with discharge Paperwork and on his forehead. Hospital states done for and came negative."

Review of a Personal Service Plan that was completed at admission on revealed it noted: "People over are at a greater risk for . While all cannot be prevented, certain interventions may reduce the risk. Brookdale's management program includes three core elements applicable to all residents: Environmental Awareness, Functional Status and Medical Condition resident was a risk.
Interventions included in resident's Personal Service Plan noted: Potential interventions - sometimes interventions that may be utilized for management are declined by residents and /or their legal representative after weighing the benefits to the resident versus the impact to their independence, lifestyle, willingness to engage in change and/or cost. Potential interventions specifically chosen by the Resident and/or legal representative not to be used:
Further review of the Personal Service Plan revealed it was not individualized according to the resident's needs but was a general plan used by the facility."

Review of results obtained on after a revealed the following:
Internal fixation of healing Tachometric right , and development of 2 focal oblique cortical in the lateral cortex of the , shaft extending to the , surface, this represents interval change, additional imaging may be considered.

There was an order from the health care provider dated to hold , , , and , due to , .
On there was an order from the health care provider that note the resident may bear to right , as tolerated; may continue with ADL's as tolerated. According to the result on
There was no documentation found in the record to confirm there were proactive measure to minimize the that resulted in injuries. According to the result on the resident sustained another to his , there were not notes regarding the second , and any interventions in place to keep the resident safe.

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On at 12:08 pm staff I a caregiver who worked in memory care said resident #7 sustained the on his forehead from a he had out of bed. She said he received a new hospital bed on .

On at 3 PM caregiver B in the memory care unit was asked about proactive measure to keep the resident staff. She said the resident's bed was lowered and a mat next to his bed in case of a . She said she was not told of any interventions regarding the resident's . She said she was the staff that the resident scratched when he was agitated, she said he would become aggressive and the caregiver would let him calm down before attempting to provide care or give him medications.

Further record review revealed there was no documentation to confirm that the health care provider and family was notified of the resident's agitation and behavior changes. There was a note that documented the resident returned from the hospital on . However, there were no notes that indicated what had transpired requiring the resident to obtain medical attention.

Review of the hospice notes revealed he started receiving hospice services on and there was no documentation in his record that noted his decline that resulted in the need of hospice services.

On at 5 PM, the health and wellness director said resident #7 had a on , she said the staff documented it in the unit but did not document what had occurred, and that the family and health care provider was contacted when the resident was sent to the hospital in his record as required. She confirmed there was no documentation to confirm interventions the facility was taking to minimize the residents and to keep him safe and also there was no documentation of the resident's decline in health that resulted in the need of hospice services.

2. On at 9:55 a.m. the wife of resident #5 said that in approximately , while assisting her husband with a shower, she observed "road " on the left side of his and a "red spot" on the bottom of his , . She discussed her findings with the facility's administrator, who told her he was aware and had conducted an investigation on the day before she reported it to him. She said the local police department were notified, came to the facility and conducted an investigation, and approximately weeks ago the information was forwarded to the State Attorney's office. A home health nurse was brought in by the facility to treat the on his .

On at 10:30 a.m., the administrator confirmed the report given by the resident's wife was accurate, that the facility conducted an investigation into allegations of on this resident on , and the Department of Adult Protective Services and the local police department each conducted their own investigations.

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Resident #5's record revealed a facility admission date of . His diagnoses included . The record did not contain facility documentation regarding the on his and documentation to indicate the facility notified his wife of the investigation and the prior to her own discovery.

On at 4 p.m., the director of nursing confirmed the findings and was unable to provide additional documentation.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on record reviews and interviews, the facility failed to follow its resident policy and procedure when 1 of 6 caregivers failed to immediately notify someone of alleged (H).

Findings:

On at 9:55 a.m., the wife of resident #5 said that in approximately , while assisting her husband with a shower, she observed "road " on the left side of his and a "red spot" on the bottom of his . She discussed her findings with the facility's administrator, who told her he was aware and had conducted an investigation on the day before she reported it to him. She said the local police department were notified, came to the facility and conducted an investigation, and approximately weeks ago the information was forwarded to the State Attorney's office. A home health nurse was brought in by the facility to treat the on his .

On at 10:30 a.m., the administrator confirmed the report given by the resident's wife was accurate, that the facility conducted an investigation into allegations of on this resident on , and the Department of Adult Protective Services and the local police department each conducted their own investigations.

Resident #5's record revealed a facility admission date of . His diagnoses included and indicated that he posed a danger to himself or others.

During a phone interview with former caregiver H on at 4:09 p.m., she said that on she worked the 11 p.m.-7 a.m. shift with former caregiver G. At approximately 1 a.m. on , she and caregiver G were walking resident #5 down the hallway to his room. He became combative so she stepped . He threw a punch at caregiver G, who tried to grab the resident's arms, so the resident

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dropped to the floor and would not get up. Caregiver G then grabbed the resident by his and dragged him down the hallway. There was on the carpet and she told caregiver G that he needed to report the incident to the director of nursing. She observed a on the resident's right and his . A nurse was not in the facility, so she performed first aid. She did not notify a supervisor of what she observed but rather she told caregiver G multiple times that he needed to report it. The director of nursing called her the next morning to check on her, and when she questioned the director as to whether she was told about the incident between the resident and caregiver G, the director said it was the first time she was hearing about it.

The facility's , neglect and , policy indicated that any associate who witnessed or became aware of alleged , neglect or , should report such incident to the executive director or supervisor on duty immediately. Therefore, caregiver H failed to follow the facility's policy when she did not immediately notify someone when she observed an incident of alleged .

A facility's summary of the investigation indicated that the director of nursing was informed of the on his on at 6:45 p.m., when a nurse conducted a skin check and saw the , which was approximately 18 hours after the incident.

Class III

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

Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) was updated for 1 of 3 sampled residents who required medication administration (#5).

Findings:

Resident #5's record revealed a facility admission date of . His 1823 health assessment form, dated , indicated that he required medication administration.

His MOR listed , tablet 0.5 milligram (mg.) give 1 tablet by three times a day for behaviors at 8 a.m., 2 p.m. and 8 p.m. The 2 p.m. dose on and was not signed as given. The MOR did not contain documentation to indicate why.

On at 4:39 p.m., the director of nursing said the medication was given however, the staff just did not sign the MOR.

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Class III

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

Based on observation, record review and interview the facility failed to ensure 1 direct care staff obtained current documentation of freedom from communicable , (D), and 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 (B) to administer medications to 1 of 3 sampled residents (#5).

Findings:

Review of the personnel record for staff B, caregiver hired , revealed a document indicating freedom from dated . Further review did not reveal any statements from a licensed healthcare provider documenting freedom from ( ) in 2018.

1. Registered Nurse (RN) D's personnel record revealed she was hired in 2010. There was no evidence to confirm she obtained a healthcare provider statement that indicated freedom from communicable including .

On at 3 PM, the business office manager said the staff did not have the healthcare provider statement.

2. Resident #5's record revealed a facility admission date of . His admission 1823 health assessment form, dated , indicated that he required medication administration, which required a licensed person to do. He had a diagnoses of .

On at 3:30 p.m., unlicensed caregiver B said she assisted resident #5 with his medications on .

Resident #5's Medication Observation Record (MOR) listed , 10 milligram (mg,) 5 mg., 220 mg., , , 125 mg., , 100 mg. and , 0.5 mg. The initials and staff signature list revealed that caregiver B signed that she gave resident #5 these medications on . As an unlicensed caregiver, she was not allowed to administer medications.

On at 3:45 p.m., the director of nursing confirmed the findings.

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Class III

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

Based on personnel record review and interview, the facility did not provide or arrange for 1 of 5 sampled staff to attend a 1 hour in-service training regarding the facility's elopement response policies and procedures, facility emergency procedures, including chain-of-command, and staff roles relating to emergency evacuation (E).

Findings:

Registered Nurse (RN) E's personnel record revealed a hire date in 2010. A certificate, dated , indicated 1 hour elopement in-service at Brookdale, and a certificate dated indicated in-service on emergency procedures and fire safety. The certificates were signed by the district director of operations. There was no evidence the trainings were specific to the facility, it only indicated "Brookdale".

On at 3 PM, the business office manager confirmed the in-service was not from the facility but for the corporation.

Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on observation, personnel record review and interview, the facility failed to ensure 2 of 5 direct care staff received 4 hours of 's and Related (ADRD) continuing education annually (A & B).

Findings:

Observations made on at 9:10 a.m. revealed the facility had a secured memory care unit.

1. Caregiver A's personnel record revealed a hire date of and a certificate for an annual 4 hour ADRD training, update dated . There were no certificates documenting the required 4 hours of annual update training in 2018.

2. Caregiver B's personnel record revealed a hire date of , and a certificate for an annual 4 hour ADRD training, update dated . There were no certificates documenting the required 4 hours

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of annual update training in 2018.

On at 3:30 p.m., the assistant executive director confirmed the findings.

Class III

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

Based on personnel record review and interview, the facility did not provide or arrange for 1 of 5 sampled staff to attend a 1 hour in-service training regarding the facility's ( ) policies and procedures (E).

Findings:

Registered Nurse (RN) E's personnel record revealed a hire date in 2010, and a certificate, dated , that indicated 1 hour in-service at "Brookdale". It did not indicate that it was specific to the facility. The certificate was signed by the district director of operations. There was no evidence she attended an in-service training regarding the facility' policies and procedure related to .

On at 3 PM, the business office manager confirmed the in-service was not from the facility but for the corporation.

Class III

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

Based on personnel record review and interview, the facility failed to ensure that all training certificates met the requirements as specified in 58A-5.0191(12) FAC for 1 of 6 sampled staff (E).

Findings:

Registered Nurse (RN) E's personnel record revealed a hire date in 2010, and a certificate that indicated in-service training regarding recognizing , neglect and , . However, the certificate was not dated.

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

Class III

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

Based on personnel record review, Agency Background Screening website review and interview, the facility failed to maintain the current background screening eligibility status in the personnel record for or 2 of 8 sampled staff employees (A & B).

Findings:

1. Caregiver A's personnel record revealed a hire date on . The level 2 background screen result in her record had an eligibility date of , which is expired. Review of the Agency Background screen website for staff A revealed a new eligibility date of .

2. Caregiver B's personnel record revealed a hire date on . The level 2 background screen result in her record had an eligibility date of , which is expired. Review of the Agency Background screen website for staff B revealed a new eligibility date of .

On at 3:30 PM, the assistant executive director brought in current eligibility result sheets for caregivers A & B that had been printed on , the day of the survey. She confirmed the new results were not in the personnel files.

Unclassified

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

Based on the 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 3 of 8 sampled staff employees (E, G & H).

Findings:

Review of the Agency's Background Screening website revealed that staff E, the Limited Nursing Services nurse, was not on the Clearinghouse roster for the facility. Further review found staff G was terminated in and staff H left employment in , but were listed as current employees in the Clearinghouse.

On at 4 PM, the assistant executive director confirmed the findings.

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Unclassified

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on record reviews and interviews, the facility failed to electronically submit a preliminary report within 1 business day and a full report within 15 days of an event that was reported to law enforcement.

Findings:

On at 9:55 a.m., the wife of resident #5 said that in approximately , while assisting her husband with a shower, she observed "road " on the left side of his and a "red spot" on the bottom of his . She discussed her findings with the facility's administrator, who told her he was aware and had conducted an investigation on the day before she reported it to him. She said the local police department were notified, came to the facility and conducted an investigation and approximately weeks ago the information was forwarded to the State Attorney's office. A home health nurse was brought in by the facility to treat the on his .

On at 10:30 a.m., the administrator confirmed the report given by the resident's wife was accurate, that the facility conducted an investigation into allegations of on this resident on and the Department of Adult Protective Services and the local police department each conducted their own investigations. He said the facility did not submit 1-day and 15-day adverse reports to the Agency when the police conducted an investigation, as was required.

Resident #5's record revealed a facility admission date of . His diagnoses included .

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