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	AL11965818	**10/29/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE LAKE MARY**	STREET ADDRESS, CITY, STATE, ZIP CODE **150 MIDDLE STREET** **LAKE MARY, FL 32746**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

The re-licensure survey including Limited Nursing services was conducted on . . . . . Brookdale Lake Mary Assisted Living Facility, License #10162 had deficiencies at the time of the visit.

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

Based on record review and interview the facility failed to ensure a Health Assessment form (1823) was completed 60 days prior to admission or within 30 days of admission for 1 of 2 sampled residents (#9).

Findings:

Record review for resident #9, revealed she was admitted to the facility on . . . . . Further record review revealed the only resident Health Assessment forms (1823) available for review were dated . . . . and . . . . . There was no evidence the facility had obtained a resident Health Assessment form 1823 that was completed 60 days prior to admission or within 30 days of admission as required.

On . . . . . at 4:30 PM, an interview with the Health and Wellness Director confirmed the findings.

Class III

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

Based on record review, observations and interviews, the administrator failed to monitor the continued appropriateness of placement for 1 of 4 sampled residents (#13) and retained the resident who required total care with all activities of Daily living, (ADL's) and could not transfer and developed a . . . . . which exceeded the continued residency criteria, did not obtain an updated Resident Health Assessment (AHCA form 1823) after a significant change (hospital and rehabilitation admission and . . . . .) for 2 of 4 sampled residents (#11 and #13).

Findings:

On . . . . . at 1 PM, during a staff interview, it was revealed resident#13, was total care, had a . . . on her bottom, had to be fed and did not get out of bed. The staff had to make sure she is turned in bed every 2 hours.

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Record review for resident #13 revealed she was admitted to the facility on , her admission resident health assessment form 1823 did not note any , an updated resident health assessment form 1823 that was dated , the health care provider answered yes to the question that asked if the resident had any , 3 or 4 , .

Further record review for resident #13 revealed an HBO Care Power Plan (outpatient) that was dated that noted debridement as needed, location of the noted , it noted "Patient may sit in wheelchair for short periods of time with the daughter present Roho Cushion." The primary was noted as aquacel foam adhesive. She was to return in 1 week.

On at 1:30 PM, Interview with the private duty care giver for resident #13 who stated she worked daily from 12 PM-7 PM-5 days a week. She started in working with resident #13, she said resident #13 could not do anything for herself, she had to totally be bathed and groomed and she could not walk. She said resident #13's daughter was a nurse and would change the to the resident's . She did not receive home health or hospice.

at 1:45 PM interview with the health and wellness director who said she thought resident#13 had a small to her bottom and her daughter and home health were taking care of.

On 3 PM the health and wellness director said she did observe the last week and it was a , .
She said the order in the file that was dated was what the facility were going by. She said resident #13's daughter was a nurse and provided care to the .

The health and wellness director was asked if there were any measurements available for review that would indicate whether or not the had improved within 30 days as required. The health and wellness director replied there were none.

The agency's registered nurse , made observations along with the facility's health and wellness director of resident #13's on at 5 p.m. The observations revealed the resident had , on both, her right and left , each one measured approximately 4 cm x 3 cm.

Further record review revealed there was no updated significant change resident health assessment form 1823 for when the resident developed the .

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

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2. Observation made on at 11:20 AM, resident #11 was observed ambulating and transferring from his wheelchair on his own with a slow gait when he was getting a cup of coffee at the cafe bistro.

On at 11:30 AM, an interview with resident #11, who stated he could ambulate and transfer on his own but he takes his time and goes slow.

Resident #11's record review revealed he went into hospital and then was transferred nursing rehabilitation facility on . Further record review revealed resident # 11 was discharged to the assisted living facility on . There was no documentation that the facility obtained a new Health Assessment form 1823 for the change is health status.

The most recent Health Assessment form 1823 was dated with diagnoses of: , skin redness to third (left) and he needs total assistance with ambulating, bathing, , and transferring with 2-person assist. Photographic evidence obtained.

On at 4:30 PM, during an interview with Health and Wellness Director, she confirmed there was no updated resident health assessment form. Also, she stated resident # 11 did not require total assistance with his ADL's and the form was incorrect.

Class III

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

Based on observation, resident record and interview the facility retained 1 of 3 residents (#13)who required total care with her activities of daily living and was bedridden and developed , which exceeded the Assisted Living Facility (ALF) continued residency and did not document when the resident developed the , (significant change), had no evidence to confirm the resident was receiving the care and services from the facility to meet her needs after developing the , through proactive measures/interventions to prevent a , from worsening.

Findings:

On at 1 PM, during a staff interview, it was revealed resident #13, was total care, had a on her bottom, had to be fed and did not get out of bed. The staff had to make sure she is turned in bed every 2 hours.

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Record review for resident #13 revealed she was admitted to the facility on , her admission resident health assessment form 1823 dated did not note any , . An updated resident health assessment form 1823 that was dated , the health care provider answered yes to the question that asked if the resident had any , 3 or 4 , .

Further record review for resident #13 revealed an HBO Care Power Plan (that was from an outpatient center) dated noted debridement as needed, location of the noted , it noted "Patient may sit in wheelchair for short periods of time with daughter present Roho Cushion." The primary was noted as aquacel foam adhesive. She was to return in 1 week.

On at 1:30 PM, Observations revealed resident#13 was lying in her bed, she had a private duty care giver present in the room with her. Interview with resident the private duty care giver for resident #13 who stated she worked daily from 12 PM-7 PM-5 days a week. She started in , working with resident #13, she said resident #13 could not do anything for herself, she had to totally be bathed and groomed and she could not walk. She said resident #13's daughter was a nurse and would change the to the resident's . She did not receive home health or hospice.

at 1:45 PM interview with the health and wellness director who said she thought resident#13 had a small to her bottom and her daughter and home health were taking care of.

On at 3 PM the health and wellness director said she did observe the last week and it was a , . She said she could not locate any home health notes. She further explained that the resident would get out of bed at times to sit in her wheelchair. She said the order in the file that was dated was what the facility were going by. She said resident #13's daughter was a nurse would come daily to the facility to provide care. The health and wellness director was asked at the time if there were any measurements available for review that would indicate whether or not the had improved within 30 days as required. The health and wellness director said there were none.

Further record review revealed there were no facility documentation regarding when the , developed, the treatment and preventative measures that were provided by the facility and the stage and measurements of the .
There was no documentation to confirm that the facility was aware of the condition of the . The facility's wellness director first stated when asked about the that it was only an .
Further record review revealed on there was a health care provider's order for a Hospice consult. On at 3::30 PM, the wellness director said resident #13's family did not want hospice

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services at that time.

The agency's registered nurse made observations along with the facility's health and wellness director of resident #13's on at 5 p.m. The observations revealed the resident had on both, her right and left , each one measured approximately 4 cm x 3 cm. She was lying on an air mattress, a pressure reduction cushion was observed in her chair.

On at 5:30 PM, the health and wellness director confirmed the findings.

Class II

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

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed caregiver (F) who assisted a resident (#5) with self-administered medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #5 on at 9:45 a.m. revealed unlicensed caregiver F unlocked the medication cart, removed an patch from its prescription labeled box then she placed the box into the cart. She removed a prescription labeled box that contained an inhaler. Resident #5 came out of her room and sat in her wheelchair next to the cart. The caregiver sanitized her , removed medication bubble packages from the cart, told the resident the name of each medication then she popped each tablet into a soufflé cup. She handed the cup to the resident, who took them with water and without assistance. She observed the resident swallow them. She then told the resident "now I have your puffer." She primed the inhaler, instructed the resident to place her on the oral piece, then she instructed the resident to inhale and as she did so, the caregiver activated the inhaler. The caregiver then said "now I have your patch." She donned gloves, told the resident she would be removing an old patch from her , she removed the old patch then she applied the new patch on the opposite side of the resident's .

Caregiver F did not read each prescription label aloud to resident #5, as required.

On at 9:55 a.m. caregiver F confirmed the findings and said she did not know she had to read the prescription labels aloud to the resident.

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Class III

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

Based on Medication Observation Record (MOR) review and interview, the facility failed to maintain accurate MORs for 2 of 3 sampled residents (#2 and #8).

Findings:

1. On at 9:40 AM, resident #2 said the facility staff told her that she had ran out of one of her medications, she said she did not remember which one.

Resident #2's record revealed a resident health assessment form 1823 dated , the health care provider note that she required assistance with self-administered medications.

Resident #2's , and MOR noted Alenronate70 milligrams (mg) one time a day every Sunday. There was a "09" entry for the medication on and . The chart codes on the MOR noted the "09" meant "other/see nurse notes."

Review of the facility's electronic notes and the resident's record revealed there was no explanations why "09" was charted.
2. Resident #8's record revealed a facility admission date of . Her most recent 1823 health assessment form, dated , indicated that she required assistance with self-administered medications.

Resident #8's MOR contained an entry for 0.125 mg by daily for . On , , and , "09" was charted.

, 25 mg, give ½ tablet by daily for . On through , "09" was charted.

, 5 mg by daily. On , , , , and , "09" was charted.

150 mg by at bedtime for . On , , , and , "09" was charted.

The chart codes on the MOR indicated that "09" meant "other/see nurse notes" however, the only

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explanations documented in the nurse's notes were that on the facility was "waiting on pharmacy" for the and on the was "not available."

The MOR nor the resident's record contained documentation to explain why "09" was charted for any of the other dates.

On at 4:45 p.m. the administrator confirmed the findings and was unable to provide additional documentation for resident #2 and #8.

Photographic evidence obtained.

Class III

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

Based on record reviews and interview, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 1 of 3 sampled residents (#8) who received assistance with self-administered medications.

Findings:

Resident #8's record revealed a facility admission date of . Her most recent 1823 health assessment form, dated , indicated that she required assistance with self-administered medications.

Resident #8's MOR contained an entry for 0.125 mg by daily for . On , and , "09" was charted.

25 mg, give ½ tablet by daily for . On through , "09" was charted.

5 mg by daily. On , , , and , "09" was charted.

150 mg by at bedtime for . On , , , and , "09" was charted.

The chart codes on the MOR indicated that "09" meant "other/see nurse notes" however, the only

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explanations documented in the nurse's notes were that on the facility was "waiting on pharmacy" for the and on the was "not available."

The MOR nor the resident's record contained documentation to explain why "09" was charted for any of the other dates and no documentation to indicate the facility made any efforts to ensure the was available on and the was available on .

On at 4:45 p.m. the administrator confirmed the findings and was unable to provide additional documentation.

Photographic evidence obtained.

Class III

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

Based on personnel record reviews and interviews, the facility failed to ensure 1 of 5 personnel records (D) contained documentation of a negative ( ) exam on an annual basis and failed to ensure 1 of 5 staff (E) submitted a written statement from a health care provider documenting freedom from communicable within 30 days after beginning employment.

Findings:

1. Caregiver D's personnel record revealed a hire date of . The record contained a written statement, dated , from a health care provider documenting freedom from communicable , including however, the record did not contain documentation to indicate caregiver D had a negative annually thereafter, as required.

2. On at 9:30 a.m. the health and wellness director identified nurse E as the nurse who conducted monthly assessments on those residents who received a Limited Nursing Service (LNS) and she began providing the service on . Nurse E's personnel record did not contain a written statement from a health care provider documenting freedom from communicable , as required.

On at 4:40 p.m. the business office manager confirmed the findings and was unable to provide additional documentation.

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0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on personnel record review and interview, the facility failed to ensure that a staff member who held a currently valid card that documented the completion courses in First Aid and was in the facility at all times.

Findings:

Review of the staff scheduled revealed staff G and Staff H worked the 11 PM-7 AM shift alone on and on at 11 PM-7 AM staff D, G and H were scheduled to work together.

Personnel record review for Staff D, G and H revealed there was no documentation to confirm the staff had completed courses in first aid and . On , the administrator's aid she was sure that staff D had 1st aid and and she could not reach her to confirm. She said staff H's and First aid expired as of and staff G had no documentation to confirm she had ever completed a First Aid and course.

The administrator said at 6 PM, that she found a staff that would work the 11 PM-7 AM shift that had a current First Aid and Card.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on personnel record reviews and interview, the facility failed to ensure 1 of 3 unlicensed caregivers (D) who assisted with self-administered medications received the initial 4 hour training on providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility (ALF.)

Findings:

Unlicensed caregiver D's personnel record revealed a hire date of . The record did not contain the required initial 4 hour training on providing assistance with self-administered medications and safe medication practices in an ALF.

On at 4:40 p.m. the business office manager confirmed the findings and was unable to provide

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additional documentation.

On at 4:55 p.m. the health and wellness director said caregiver D began assisting residents with medications this month.

Class III

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

Based on observations and interviews, the facility failed to provide and maintain carpets free of stains and a home-like and decent environment in which to provide a safe living environment.

Findings:

1. Observations on at 10 AM in revealed there were numerous black stains in the carpet in the kitchen/dining room area.

The Wellness director was present and confirmed the findings.

2. Observations made during an interview with resident #7 on at 10:20 a.m. revealed her bedroom carpet was stained in multiple areas. She said the facility last cleaned her carpet a year ago.

On at 1:01 p.m. the health and wellness director said she was aware of the stained carpet and said the carpet had been previously cleaned on multiple occasions but the stains were deep.

On at 3 p.m. the administrator too confirmed the condition of resident #7's carpet and said the facility's process for carpet cleaning was once a year.

Photographic evidence obtained.

Class III

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

Based on record reviews and interview, the facility failed to ensure the record for 1 of 2 sampled residents (#8) contained a signed written informed consent for unlicensed staff to assist residents with self-administered medications.

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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 #8's record revealed a facility admission date of . Her most recent 1823 health assessment form, dated , indicated that she required assistance with self-administered medications.

Resident #8's residency agreement contained a written informed consent for unlicensed staff to assist her with medications however, the form was not signed by the resident or legal representative.

On at 4:35 p.m. the business office manager confirmed the findings and was unable to provide additional documentation.

Photographic evidence obtained.

Class

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

Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled resident contracts (#8) contained all of the required and correct information.

Findings:

Resident #8's residency agreement, dated , did not contain a provision indicating whether or not the facility was associated with a religious affiliation and a provision that indicated a new 1823 health assessment form had to be completed at least every 3 years or after a significant change but rather, the contract indicated the resident was required to obtain a new 1823 annually.

On at 4:35 p.m. the business office manager confirmed the findings and was unable to provide additional documentation.

Photographic evidence obtained.

Class

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N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on observation, record review and interview, the facility failed to obtain an order for [redacted] for 1 of 1 sampled residents (#9) that received Limited Nursing Services (LNS) as required.

Findings:

Observation on [redacted] at 10:20 AM in resident #9's room the [redacted] machine was running continuously on 2 liters.

On [redacted] at 10:30 AM, an interview with resident #9 who stated she can put on her own [redacted], but she does not touch the dial for the liters because the nurse adjust liters and turn it on for her.

On [redacted] at 2:50 PM, an interview with the wellness nurse who stated that she had been assisting resident #9 turning the [redacted] machine on and off since started working at the facility in [redacted] of 2018

Resident #9's record review revealed there was no order for the [redacted].

On [redacted] at 5 PM, an interview with the Health and Wellness Director confirmed the findings.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on record reviews and interviews, the facility failed to maintain nursing progress notes for 1 of 3 sampled residents (#8) and failed to maintain monthly nursing assessments for 1 of 3 sampled residents (#9,) both of whom received a Limited Nursing Service (LNS.)

Findings:

On [redacted] at 9:25 a.m. the health and wellness director identified resident #8 and said she received a LNS for [redacted].

A health care provider's order, dated [redacted], indicated that resident #8 was to use [redacted] at 2 liters/minute via a [redacted] continuously.

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Review of resident #8's LNS nursing progress notes revealed that during the month of , a progress note was not written on , , through and , as required.

On at 4 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Observation on at 10:20 AM in resident #9's room the machine was running continuously on 2 liters.

On at 10:30 AM, an interview with resident #9 who stated that she can put on her own , but she does not touch the dial for the liters because the nurse adjust liters and turn it on for her.

On at 2:50 PM, an interview with the wellness nurse who stated that she had been assisting resident #9 turning the machine on and off since she starting working at the facility in of 2018.

Resident #9's record review revealed no monthly nursing assessment and no nursing progress notes for the Limited Nursing Services provided ( ).

On at 5 PM, an interview with the Health and Wellness Director confirmed the finding.

Class III

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

Based on personnel record review, background screening website and interview, the provider did not maintain the current Level II Background screening eligibility results for 2 of 5 sampled staff (C and E) in their personnel files.

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Findings:

1. Personnel record review for staff C hired revealed the background screening document in her record noted "Awaiting Privacy Policy. There was no way to determine whether or not staff she had an eligible background screening result when reviewing the documentation.

Review of the Agency's online background screening website on at 3 PM revealed staff C had an eligible screening result that was dated .
2. On at 9:30 a.m. the health and wellness director identified nurse E as the nurse who conducted monthly assessments on those residents who received a Limited Nursing Service (LNS) and she began providing the service on .

The most recent eligible background screening results in nurse E's personnel record was dated therefore, she required a new screening.

Review of the Agency's online background screening website on at 3:05 p.m. revealed nurse E had an eligible screening on however, the result of the screening was not in the personnel record, as required.

On at 4:35 p.m. the business office manager confirmed the findings.

Unclassified