STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965390	11/05/2018
NAME OF PROVIDER OR SUPPLIER **BROOKDALE WEST MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7199 GREENBORO DR MELBOURNE, FL 32904**	

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

0000 - Initial Comments

A Complaint Investigation #2018014072 was conducted on . . . . , ... and . . . . . Brookdale West Melbourne, License #9766, had a deficiency found at the time of the visit.

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

Based on record review and interviews, the facility failed to provide appropriate supervision to 3 of 4 sampled residents (#1, 2 & 3) when resident #1 began a pattern of . . . . . behavior that included fondling, kissing and activity with female residents (#2 & 3), and did not notify the responsible parties and healthcare providers.

Findings:

1. Resident #1 had a health assessment report 1823 dated . . . . . that indicated diagnosis of . He was independent with all activities of daily living (ADLs). He was on no medications at the time, was appropriate for assisted living. An order dated . . . . . indicated diagnosis of hyper , , and , , , a type of female hormone (progestin), 5 milligrams daily was prescribed (webmd.com).

Hospital discharge summary dated . . . . indicated a . . , ... with history of likely . . . . . admitted to medical floor because of . He was from jail, and was in jail due to trespass.

Facility notes indicated that on:
- new admit alert/oriented to person/place
. . . . . shift - resident #1 was found kissing resident #2, separated from this resident. Executive Director (ED) notified via text.
. . . . . - Resident #1 found in the room of resident #2. It appeared he had unbuttoned her shirt and was fondling her , telling her she looked beautiful and left great. The other resident was "no longer able to dress self or undress self for that matter". The other resident did not understand was resident #1 was doing; he was re-directed to his room. The door of resident #2 was locked from the inside (she could leave but not come in). She did not attempt to leave the room with resident #1. Incident report incident report was filed on line reporting (corporate system).

at 8:30 PM - resident was overheard trying to coax another female resident into his room. The resident told him no and swatted his . . away.

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at 11 PM - resident was noted without pants. He was opening another resident's door. Instructed to go to his room and put pants on. Once again opening another resident's door. Instructed to go to his room and put his pants on. He went to room but 15 min later a resident attendant ( ) noted resident #1 walking down the hall without pants and holding his .

10 PM - reported resident was peeking through door as she helped a female resident change into bed clothes. told resident to go to his room and closed female resident's door.

shift late entry for - resident #1 was in B hallway along with resident B-8 and writer. Resident in B-8 said to writer "that man". Resident was taken to B8 and asked why she said "that man". "He tried to get fresh with me and I wasn't having it." The resident did not appear to be threatened at all - will continue to monitor.

There were no written evidence to confirm what interventions were put in place to ensure resident #2 did not engage in activity with the female residents and how he was going to be monitored.

Resident #1 was discharged from the facility on .

2. Resident #2 had an updated health assessment report 1823 dated that listed diagnoses of , , , and . According to the report she was awake, alert with , thinking. Precautions indicated . On , the court determined her with total incapacity.

Facility notes indicated that on:
- resident #1 kissed her. She did not appear to be in any distress. They were separated ED and responsible party notified.

time not indicated - resident #1 was found in resident's room fondling her . She appeared not to understand what was happening. Resident #1 said he was sorry. Her door was locked from inside so only staff could enter with a key. Guardian notified.

- Resident's doctor came in and wrote order to discharge resident. Power of Attorney (POA) contacted and was already aware. Asked to get resident ready for discharge. Picked up at 2:30 PM.

Resident #3 was discharged from the facility on .

3. Resident #3 had an updated health assessment report 1823 dated that listed

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, high , and . According to the report she was alert x 1 able to follow simple commands, was under the care of hospice. She was independent with transfers, supervision was needed with ambulation, eating, toileting, and assistance was needed with bathing, /grooming. She was admitted to hospice on . Facility note dated resident moved out of facility with daughter.

In an interview on at 5 PM, the resident's daughter said that she was contacted by Adult Protective Services informed that her mother had been found with resident #1 having . Her mother lacked capacity to give consent; she was raped. The facility never called her about the situation. She would relocate her mother to another facility.

A Brookdale training guide entitled in Aging indicated: fondling or intercourse - response report to ED or Health Wellness Director (HWD) as soon as behavior was observed. Contact both families early on when behavior was noticed - even just holding. For intimate situations- separate residents respectfully, notify supervisor, and responsible party, the physician, ED, document in resident's record. If either one or both of the residents engaged in activity are and there is no documented agreement about their relationship, associates should take measures to respectfully separate the individuals, notify ED, HWD or supervisor in charge so ED can begin an investigation. The investigation should include contacting the resident's responsible party and physician. In instances when one of the parties involve verbalize or exhibits discomfort the act may be considered and must be reported immediately.

The facility did nothing more than re-direct the resident. There were no other systems put in place to ensure the other residents were not subject to his behavior.

On at 2 PM, the HWD said if any resident showed any form of distress it would need to be reported to the ED and families. The resident's daughter was upset but her other daughter was understanding.

On at 2 PM, the ED said she did not call families because there was nothing to report, nothing happened. The Brookdale policy about was explained to families at the time of admission, so they would know what to expect.

On at 2 PM, staff A said she heard a noise, went to see, and found residents #1 and #2 engaged in activity. She said resident #3 seemed pleased. She was not in any distress. They were redirected. The residents were in the room of resident #1. She added resident #3 at night. Normally she would be assisted to bed and then she would get up and .

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On review of facility records revealed a 1 hour training on , rights and ¸ was conducted on by the administrator. The sign in sheets were reviewed. The administrator also had a discussion with the staff during a staff meeting on on " in the Building ". A training on " ¸ in Aging' was done on7/26/18 by the Corporate Register Nurse.

Exit interview was conducted on at 2:45 with the Health and Wellness Director.

Class II