STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964477	02/14/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE PORT CHARLOTTE**	STREET ADDRESS, CITY, STATE, ZIP CODE **18440 TOLEDO BLADE BLVD** **PORT CHARLOTTE, FL 33952**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR #20180017158 was conducted on at Brookdale Port Charlotte, an assisted living facility (license #9027) in Port Charlotte, Florida.

The complaint contained 1 allegation which was substantiated.

The following is a description of the deficiency.

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

Based on record review, observation and resident and staff interviews, the facility failed to provide nursing supervision for 2 (Resident #2 and #3) out of 3 residents with a history of .

The findings included:

1. Review of Resident #2's clinical record on , revealed the resident had a on that resulted in and hospitalization. The resident had 3 in and another on , all resulting in minor injury and a visit to the hospital. The resident received , , in and and the physician ordered a walker for use by the resident to prevent .

The resident experienced another on resulting in a on his right . There was no documentation on record that indicated the resident was using his walker at this time. There was no documentation on record that indicates the resident refuses to use a walker.

Interview with the resident on at 12:30 a.m., found him to be alert and oriented. The resident was observed ambulating in the hallway without a walker status post lunch at 1:00 p.m. Staff did not intervene to assist the resident or provide him with his walker. The resident was observed again at 3:15 p.m., sitting in a chair in the front lobby. He did not have a walker near him. Facility staff were in the area but did not intervene to obtain the resident's walker. Observation of his room at this time with the Executive Director present, revealed a wheelchair and 2 walkers. The Executive Director acknowledged that the resident should have been provided with a walker.

2. Review of Resident #3's clinical record on , revealed the resident had 3 without injury in . The resident attended physical and , , status post these , and a wheelchair with , , and a mechanism to recline the was initiated. On and

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the resident out of the wheelchair in the dining room.

Resident #3 was observed, at 12:32 p.m., on eating lunch in the dining room. She was sitting in a wheelchair and was using adaptive utensils with her right . She was sitting in a wheelchair with the in an upright position and the resident was leaning slightly to her right side. The resident was observed again at 3:20 p.m., at an activity. The of her wheelchair was in an upright position and the resident was leaning forward trying to reach her right . The Executive Director, present at this time, intervened to reposition the resident and her wheelchair's tilting mechanism.

During an interview, at 4:15 p.m., on the Executive Director said the plan to prevent recurrence of , was to re-educate the staff on use of the wheelchair and use of the reclining mechanism. She also said that the chair prevents the resident from leaning forward and leaning to the right, when the is reclined; referencing the 3:20 p.m. observation of Resident #3 at an activity this date.

The resident was observed again on at 5:15 p.m., in the dining room at the evening meal. The resident was leaning forward in her wheelchair and leaning profoundly to the right. It was noted at this time the wheelchair was not tilted . The Executive Director was apprised of this observation and acknowledged that all staff had been in-serviced regarding the correct use of the wheelchair (to prevent).

Class III