STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964062	04/08/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE VERO BEACH SOUTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **410 4TH COURT** **VERO BEACH, FL 32962**	

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

0000 - Initial Comments

An unannounced relicensure survey with LNS (Limited Nursing Service) survey was conducted on at Brookdale Vero Beach South. The facility had deficiencies at the time of the visit.

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

Based on observation and interview it was determined the facility failed to provide each resident with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S., and that the required posting of phone numbers be in close proximity to this accessible telephone.

The findings included:

During observation and interview conducted with the ED (Executive Director), on beginning at approximately 9:20 AM, she was asked if each resident had their own private telephone (land line or cell phone). The ED acknowledged that not each resident has their own private telephone. She was asked how residents without their own private telephone has unrestricted access to make a private telephone call. She stated all they have to do is ask and they can use her office phone or the receptionists phone. She was asked how that meets the requirement of unrestricted access to make a private telephone call, if they have to ask permission to use the phone and therefore staff would know they made a phone call. She could not provide an explanation as to how this meets the requirement to unrestricted access to make a private phone call.

Class

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review and interview, the facility failed to ensure that a medication was administered in accordance with the manufacturer's instructions, for 1 of 5 sampled residents (Resident # 2)

Findings include:

An observation of medication assistance was conducted on at 8:23 AM. The Medication Nurse handed a Handihaler (inhalation medication device) to Resident # 2. She did not provide the resident with a cup of water and a empty cup to rinse and spit in after inhaling the medication. The nurse

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then handed the resident a cup with her other pill form medications and a glass of water. When the resident had finished taking her pill medications, the nurse handed her a inhaler and instructed the resident to inhale the medication. The nurse did not instruct the resident to swish and spit after inhaling the , inhaler medication. After the resident had finished the medication, the Nurse handed the resident a capsule of medication (liquid) and reminded her to use the medication which is a medication. She stated that the resident had the device in her room and preferred to take it in her room. . The Nurse did not follow the resident to her room or observe her placing the inhaler medication into the and inhaling the medication.

At 10:30 AM, the surveyor conducted a review of the Physician's Desk Reference on line which revealed that a patient should swish and spit with water after taking both the , Handihaler inhalation medication and the inhalation medication in order to prevent . The surveyor asked the Medication Nurse if she should give Resident # 2 a cup of water and an empty cup to swish and spit after consuming the Spiria inhaler and the . The Nurse confirmed that this needs to occur to prevent , an oral . The Nurse confimed that she should have given the resident the water and cup to do this after both medications. The Nurse was then asked why she did not observe Resident # 2 place the ampoule into the container and initiate the treatment. The Nurse stated that the resident prefers to do it in her room and she has watched her do it in the past. The Surveyor asked the Nurse why the facility administered the other medications, but allowed her to complete the Brovna treatment in her room. The Nurse stated that the resident is forgetful and has .

A review of the AHCA 1823 dated //17 for Resident # 2 revealed that both boxes for needs medication assistance and does not require medication assistance were checked. The surveyor asked the nurse which of the two boxes should have been checked. She confirmed that there was no clarification in the record as to which medications the resident could safely take on her own and which required supervision. The Health and Wellness Director was asked and confirmed that the facility should have clarified this order and not allowed the resident to self administer any medication until this was completed.

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on interview and record review, it was determined the facility failed to maintain documentation of and training (conducted within 30 days of employment) in each staffs file for 3 of 3 sampled staff (Staff A, Staff B, and Staff C).

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The findings included:

During interview and staff record review conducted with the ED (Executive Director), on . . . . . beginning at approximately 11:50 AM, she was provided the opportunity to locate and training documentation in the following staff files:

1) Staff A with a date of hire noted as . . . . .
2) Staff B with a date of hire noted as
3) Staff C with a date of hire noted as . . . . . .

The ED acknowledged and training was not located in each of the above noted staff files during this interview and record review.

Class III

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

Based on interview and record review, it was determined the facility failed to maintain certificates, or copies of certificates, of trainings required by this rule in each staff's file, for 3 of 3 sampled staff (Staff A, Staff B, and Staff C).

The findings included:

During interview and staff record review conducted with the ED (Executive Director), on . . . . . beginning at approximately 11:50 AM, she was provided the opportunity to locate certificates, or copies of certificates, of trainings required by this rule in the following staff files:

1) Staff A with a date of hire noted as . . . . . :
a. Preservice Orientation (2 hours)
b. . . . . Control (1 hour)

2) Staff B with a date of hire noted as . . . . . :
a. Control (1 hour)

3) Staff C with a date of hire noted as :
a. Preservice Orientation (2 hours)

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b. Control (1 hour)
c. Resident Rights & Recognizing and Reporting Resident , Neglect, and (1 hour)

The ED acknowledged the above noted training certificates were not located in each of the above noted staff files during this interview and record review.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on interview and record review it was determined the facility failed to ensure the approved Emergency Power Plan is "readily available" to assisted living facility staff so they can immediately produce the plan as well as the plan's policies and procedures for implementation, either in electronic or paper format, upon request. In addition, upon submission of the plan to the local emergency management agency and upon final implementation of the plan by the assisted living facility each facility must maintain a copy of each notification set forth and be readily available at the facility's physical address either in electronic or paper format upon request.

The findings included:

During interview and review of the facility's Emergency Power Plan conducted with the ED (Executive Director), on , beginning at approximately 10:40 AM, she was asked where this plan is located. She stated there is one in her office and one in the locked cabinet in the receptionist's office. She was asked if all staff has access to her office. She stated they do not. She was asked if all staff has access to the locked cabinet in the receptionist's office. She replied that they do not. She was reminded that all staff are to have access to this plan. The ED was asked for documentation that each resident and/or their representative had received a letter related to the implementation of the facility's Emergency Power Plan. She acknowledged not all residents and/or their representatives had received a letter regarding the implementation of this plan.

Class

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

Based on interview and record review it was determined the facility failed to ensure a signed Attestation referenced in subsection 59!-35.090(2), F.A.C. must be in each staff member's personnel file, maintained by the provider for 2 of 3 sampled staff (Staff A and Staff C).

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The findings included:

During interview and staff record review conducted with the ED (Executive Director), on . . . . . beginning at approximately 11:40 AM, she was provided the opportunity to locate a completed and signed Attestation form for the following staff members:

1) Staff A with a date of hire noted as
2) Staff C with a date of hire noted as . . . . .

The ED acknowledged this required documentation was not on file at the time of this review.

Unclassified