STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965474	02/27/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE WEKIWA SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703**	

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

0000 - Initial Comments

A Limited Nursing Service (LNS) monitoring visit was conducted on . Brookdale Wekiwa Springs, license #9829, had deficiencies at the time of the visit.

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

Based on record reviews and interviews, the facility failed to follow health care provider orders for 1 of 1 sampled resident (#1).

Findings:

Observations made on at 9:40 a.m., revealed resident #1 sat in a chair in the day room of memory care. A gauze was wrapped around her left arm and was anchored with gauze around her .

On at 9:45 a.m. nurse A said resident #1 had a with to her left arm and her skin was weeping, so she applied the gauze. She said the resident went to the hospital on and returned on with a sling for her left arm but the sling could not be located and perhaps it was in the laundry. She made the makeshift gauze sling when the sling could not be located.

On at 9:50 a.m. the administrator said she realized that morning that the sling was not available when she went over to check on the resident.

On at 10 a.m. observations were made of the gauze sling with the administrator, who said nurse A should not have applied the makeshift sling and she believed the resident's sling did not return with her from the hospital on .

Resident #1's record revealed a facility admission date of . A current 1823 health assessment form, dated , indicated that her diagnoses included , , history of , Dyslipidemia, , , , , , and generalized . She was a risk and required assistance with all of her Activities of Daily Living (ADLs).

Facility notes revealed that on at 1:10 p.m., a caregiver reported that the resident , a was observed on the left side of her , and she complained of left arm and . A health care provider ordered for her to be sent to the emergency room. On at 6:30 p.m., the resident returned to the facility.

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Hospital discharge instructions, dated ... and electronically signed by a health care provider, indicated that resident #1 had an acute left . A sling was to be applied to gravity for comfort, ice 20 minutes on and 20 minutes off for today and tomorrow, and follow up with an orthopedic doctor. The phone number for the follow up was provided.

A facility note, dated at 10:42 p.m., indicated that she returned from the hospital with a sling.

On at 2:56 p.m. she had an unwitnessed . She was sent to the emergency room.

On at 7:37 a.m. a report was received from a nurse at the hospital. The resident was admitted with and . An of her left arm revealed a with increased displacement.

On between 8:30 p.m. and 9 p.m. the resident returned to the facility.

On at 7 a.m. she was observed in the bed. She opened her when her name was called, and when asked if she was in , she frowned and was . Her left arm was in a sling with some , was visible, and she moved her .

On at 11:09 a.m., the administrator said since nurse A saw the sling when the resident returned from the hospital on ..., she would search the facility for the sling.

On ... at 11:15 a.m. the administrator said she spoke with nurse A and although the nurse wrote that she saw the sling on , that was not true and she did not see a sling.

At 12:05 p.m. nurse A said that on she saw something wrapped around the resident's arm that she believed it was a sling.

The resident's record did not contain documentation to indicate the facility contacted the hospital to inquire whether the sling was there and no documentation to indicate a health care provider was contacted for instructions when the sling could not be located and prior to applying a makeshift sling.

There was no documentation to indicate the orthopedic doctor was contacted for follow-up and no documentation that ice was applied for 20 minutes on and 20 minutes off as instructed to do on the hospital discharge instructions on ... .

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On at 1:05 p.m. the health and wellness director confirmed the findings, said ice was not applied as instructed, and a follow up call was not made to the orthopedic doctor.

Resident #1's record contained a health care provider's order, dated , for home health care skilled nursing to apply , telfa, and kling to a on her left every 2 days.

The record did not contain documentation to indicate the home health service was ever provided.

On at 3:45 p.m. the health and wellness director said she could not provide documentation to indicate the resident received the home health service.

Photographic evidence obtained.

Class II

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

Based on record reviews and interviews, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience and allowed unlicensed staff (B and C) to provide care to 1 of 1 sampled resident (#1).

Findings:

Resident #1's record revealed a facility admission date of . A current 1823 health assessment form, dated , indicated that her diagnoses included , history of , Dyslipidemia, , and generalized . She was a risk and required assistance with all of her Activities of Daily Living (ADLs.)

The record contained a health care provider's order, dated , for home health care skilled nursing to apply , telfa, and kling to a on her left every two days.

Resident #1's Medication Observation Record (MOR) contained the order however, unlicensed caregiver C signed that she did the care on , , , , and , which is a task an unlicensed caregiver is not permitted to do.

Additionally, the MOR contained an entry to cleanse the resident's left lower arm with normal , apply , and cover with non-adherent every day until healed and the

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treatment was signed by unlicensed caregiver B on to , , , , - , and .

On at 11 a.m. caregiver B said she did not apply a to resident #1's arm but rather she applied to a on her left , which is a task that unlicensed staff are not permitted to do.

On at 11:35 a.m. the administrator said the MOR was used by the caregivers so if they documented on it then they did the treatments and said there were no home health notes to indicate a nurse performed the treatments.

Photographic evidence obtained.

Class III

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

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 5 sampled staff (A) received the required in-service training within 30 days of employment.

Findings:

Nurse A's personnel record revealed a hire date of . The record did not contain documented evidence to indicate she received the required 2 hours of preservice orientation and no documentation to indicate she ever received core training to exempt her from the 2 hours of training.

On at 2:55 p.m. the administrator confirmed the findings.

Class III

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

Based on observations, personnel record reviews and interview, the facility failed to ensure 2 of 5 direct care staff (B and C) received 4 hours of and Related (ADRD) continuing education annually.

Findings:

Observations made during a tour of the facility on at 9:30 a.m. revealed the facility had a

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secured memory care unit.

Caregiver B's personnel record revealed a hire date of . The record contained a certificate of training for level 1 and 2 ADRD training, dated . The record did not contain documented evidence to indicate she received 4 hours of ADRD continuing education annually in 2018, as required.

Caregiver C's personnel record revealed a hire date of . The record contained a certificate of training for level 1 ADRD, dated and level 2, dated . The record did not contain documented evidence to indicate she received 4 hours of ADRD continuing education annually in 2017 and 2018, as required.

On at 3 p.m. the administrator confirmed the findings.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC; 429.07 (3)(c)2, FS

Based on record review and interviews, the facility failed to ensure nursing progress notes were maintained for 1 of 1 sampled resident (#1) who received a Limited Nursing Service (LNS).

Findings:

Review of the facility's posted license revealed the facility is licensed to provide LNS.

Resident #1's record revealed a facility admission date of . A current 1823 health assessment form, dated , indicated that her diagnoses included , history of , Dyslipidemia, , , and generalized . She was a risk and required assistance with all of her Activities of Daily Living (ADLs.)

Facility notes revealed that on at 1:10 p.m. a caregiver reported that the resident , a was observed on the left side of her , and she complained of left arm and . A health care provider ordered for her to be sent to the emergency room.

On at 6:30 p.m. the resident returned to the facility.

Hospital discharge instructions, dated and electronically signed by a health care provider, indicated that resident #1 had an acute left . A sling was to be applied to gravity for

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comfort, ice 20 minutes on and 20 minutes off for today and tomorrow, and follow up with an orthopedic doctor. The phone number for the follow up was provided.

A note, dated ... ... at 10:42 p.m., indicated that she returned from the hospital with a sling, which is a Limited Nursing Service.

Resident #1's record did not contain nursing progress notes for the sling.

On at 10 a.m. the administrator said the nurses donned and doffed the sling since the resident's return on ... ... and she could not provide an explanation as to why the required LNS records were not maintained.

Class III

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Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on personnel record reviews and interview, the facility failed to ensure the personnel record for 1 of 5 sampled staff (A) contained an Attestation of Compliance with Background Screening Requirements.

Findings:

Nurse A's personnel record revealed a hire date of . . . . . The record contained an Attestation of Compliance with Background Screening Requirements however, page 4, which is the employee signature page, was not attached.

On . . . . . at 2:55 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

Unclassified

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On . . . . . at 2:55 p.m. the administrator confirmed the findings.

Photographic evidence obtained.

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