STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965818	07/01/2019
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
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced complaint investigation was conducted at Brookdale Lake Mary (2019006050), Lake Mary, Florida, on . Deficient practice was found at the time of the complaint investigation.

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

Based on record reviews and interviews the facility placed residents at-risk by failing to properly document resident for five of five residents (Resident #1, 2, 3, 4 and 5).

Findings include:

On at 11:15 AM, in an interview with the Administrator, the administrator stated the facility had an operating policy regarding . The administrator stated she could provide a copy of the operating procedure to the Agency.
On at 11:15 AM, in an interview with the Administrator and Wellness Director, they stated the facility policy for requires staff to complete a -written incident report, which is provided to the Wellness Director for review. The administrator stated if the staff feel the resident is at-risk, they (the staff) are allowed to call 911. The Wellness Director stated she reviews the incident report, and then she enters it into the electronic system and then shreds the handwritten copy.
On in a record review of the facilities management policy, the policy documents the following: (photo evidence/8)
" Notify the resident's physician/healthcare provider for evaluation, care and treatment if indicated and document in the resident record.
" Notify the resident's family/responsible party and document in the resident record.
" Document the resident /injuries, resident response and interventions taken in the resident record.
" Service plan is reviewed for potential interventions and updated as necessary.
On in a record review of the incident log, the log documented the following incidents within the last 90-days. (Photo evidence/9)
" at 6:45 AM- Resident #2 .
" at 5:35 AM - Resident #3 .
" at 5:30 PM - Resident #1 ; documentation of a cut/ and 911 was called.
" at 6:00 PM - Resident #4 , documentation of a scrape.
" at 10:25 PM - Resident #1 , documentation resident cut the , 911 called and Resident #1 was transported to a higher level of care.
" at 9:45 PM - Resident #3 , documentation of cuts on both .
" at 1:50 PM - Resident #1 , documentation of in the left .

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" at 12:55 AM - Resident #5 , documentation of redness.
On in a record review of Resident #1's progress notes, the notes failed to document Resident #1's on , Resident #1's on and Resident #11's on . The progress notes did document a by Resident #1 on , which was not included on the incident log. The progress notes did not document any contact with Resident #1's physician/health care provider or family. The progress notes for Resident #1 did not document any review of Resident #1's service plan. (Photo evidence/2)
On in a record review of Resident #2's progress notes, the notes failed to document Resident #2's on . The progress notes did not document any contact with Resident #2's physician/healthcare provider or family. The progress notes for Resident #2 did not document any review of Resident #2's service plan. (Photo evidence taken/3)
On in a record review of Resident #3's progress notes, the notes failed to document Resident #3's on and . The progress notes did not document any contact with Resident #3's physician/healthcare provider or family. The progress notes for Resident #3 did not document any review of Resident #3's service plan. (Photo evidence/6 and 7)
On in a record review of Resident #4's progress notes, the notes failed to document Resident #4's on . The progress notes did not document any contact with Resident #4's physician/healthcare provider or family. The progress notes for Resident #4 did not document any review of Resident #4's service plan. (Photo evidence 4)
On in a record review of Resident #5's progress notes, the notes failed to document Resident #5's on . The progress notes did not document any contact with Resident #5's physician/healthcare provider or family. The progress notes for Resident $5 did not document any review of Resident #5's service plan. (Photo evidence/5)
On at 4:31 PM, in an interview with the Administrator and Wellness Director, the Wellness Director stated they did not have documentation in the progress notes of residents.

Class III