Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932514	A. BUILDING: _____ B. WING _____	12/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BROOKSHIRE	85 BULLDOG BLVD. MELBOURNE, FL 32901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation #2019015391 was conducted on [redacted]. The Brookshire, Melbourne had deficiencies at the time of the visit.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to provide care and services to meet the needs of the residents on the overnight shift from 11pm- 7am. Findings: In a review of Resident#1's progress notes, on the resident called law enforcement to the facility to assist her with actvities daily living when staff was not answering her call. When Law enforcement arrived at 4am on they stated they could not access entry into the building for 1 hour due to staff' not answering the front door or the call on the cell phone. When staff finally answer their call at 4:18am they were able to get into the facility. They stated when they went to the 2nd floor they found 2 staff members asleep and a nurse in a room with the door closed. They stated staff was not aware that the resident #1 needed assistance and did not hear the call button.	A 025		

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A 025	Continued From page 2 In review of the facility's staff schedule it revealed the shift for 11pm -7am they have 3 caregivers and 1 nurse for 28 residents needing limited nursing services, 12 memory care unit residents (located on the 2nd floor) and 48 assisted living residents. The facility has 3 floors. In an interview on [redacted] at 7am with Residents#1, confirmed there is not enough staff all 3 shifts to meet the needs of the residents. In an interview on [redacted] at 7:20am with Resident#2, confirmed the overnight shift from 11pm-7am does not enough staff to meet the needs of all the residents. In an interview at 7:30am with Resident#3, confirmed the overnight shift from 11am to 7am does not have enough staff to meet the needs of the residents. In an interview with Resident#4, confirmed the overnight shift does not have enough staff to meet the needs of the residents. Resident#4 also stated residents have to wait 40 minutes or longer for a staff person attend to their needs when the call button is pushed. In an interview with Resident#5, confirmed the overnight staff from 11pm-7am is not able to meet the needs of the residents with activities of daily living. In an interview with the administrator and the director of nursing at various times starting at 6am, they stated they were not aware of the concerns of inadequate staffing with the residents; however, they confirmed the findings of inadequate supervision for the incident on	A 025		

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A 025	Continued From page 3 Class III	A 025		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or	A 165		

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A 165	Continued From page 4 its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.	A 165		

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A 165	Continued From page 5 (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Citation Text for Tag 0165, Regulation UDVI Sabat, Heather Based on facility records and interview, the facility failed to file a 1 day Adverse Incident Report as required by the agency.	A 165		

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A 165	Continued From page 6 Findings: In a review of Resident#1's progress notes, on she called law enforcement to the facility to assist her when staff was not available. Law enforcement arrived and could not access entry into the building for 1 hour due to staff's inadequate supervision on the overnight hours. When they were able to get into the facility they found 2 staff members asleep on the second floor and a nurse in a room with the door closed. In an interview with the administrator on at 1pm, he confirmed the above findings and stated an adverse incident report was not filed for the incident. Class III	A 165		