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
	AL11964916	A. BUILDING: _____ B. WING _____	07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST BOYNTON BEACH	8220 JOG ROAD BOYNTON BEACH, FL 33437

(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 An unannounced Licensure complaint survey, #2020011775, was conducted on [redacted] at Brookdale West Boynton Beach. The facility had deficiencies identified at the time of the survey. This survey was conducted in conjunction with an [redacted] Control Monitoring survey on the same date. See separate for findings.	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] or [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	A 025		

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A 025	Continued From page 1 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. (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 staff interview, the facility failed to document the contact of resident's health care provider and appropriate party for 1 of 1 residents with unintentional ␣ loss (Resident #1). The facility also failed to maintain written documentation of any changes to the plan of care to address the significant ␣ loss, or to maintain written incident report regarding . of unknown origin . The findings included: A review of Resident #1's previous health assessment (AHCA Form 1823), dated , documents Resident #1's ␣ ; The assessment notes that Resident #1 needed encouragement with eating, and he was to have	A 025		

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A 025	Continued From page 2 monthly . . recorded.. The resident was independent with all ADLs. A review of the monthly weigh-in log shows the following . . changes for Resident #1: - . . . . . - . . (-10 = 6.5% loss over 7 months) . . . . . - . . . . - . . . . - . . . . - . . . . . - . . . . - (- = 6.3% loss over 6 months) - . (- = 8.4% loss over 7 months) - . . . . . - . . . . . - (- = 14% loss over 12 months) - (+) . . . . . - . . . . (- . . = 8.3% loss over 1 month which is a significant . loss) A review of Resident #1's Progress Notes from to . . . . . contains no documentation related to the acknowledgment of any significant . . changes other than a note on . . . . and regarding a monthly . order "in the morning every month starting on the 5th for 1 day." There is also no documentation found related to the notification of Resident #1's health care provider and appropriate family member, nor changes in care to address the Resident's dietary needs. During interview with Staff A on at 1:43 PM, she stated, "The daughter had called me and asked me to weigh the resident because she said	A 025		

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A 025	Continued From page 3	A 025		

she noticed he had looked like he'd lost . when she talked to him over FaceTime. The VA nurse also contacted me. When I did the , I did notice a big drop in since the last weigh in [from to .]. I notified the VA and his daughter." The LPN had not notified family prior to regarding any of the significant losses recorded on the weigh-in log. She stated that VA had been doing televisits with the resident

On , a General Progress Note by Staff A documents: "Resident feeling weak this morning. Fluids encouraged and given. Resident appetite is poor. Nurse encouraged resident to eat breakfast. Only took a few bites of eggs. Offered pudding only took a few spoons. Cake offered also. Only a few bites taken. Drank cup of orange juice. Call placed to [ARNP (Veteran's Administration)] message left for on voicemail. [VA] returned the call after speaking with daughter. Awaiting orders."

During record review for Resident #1, the Progress Notes dated also documented, "Resident coming from the bathroom noted with to his left upper arm. First Aid applied. Resident is unaware how he received . Stated he thinks he . [Daughter] notified."

During interview with Staff A conducted on at 1:43 PM, she stated, "On , I noticed a on [Resident #1's] left upper arm. The Resident could not tell me how he got the ." The nurse indicated with her that the had been approximately 4 inches long. She said, "There was on the sheet, but no where else in the room, so I didn't think it was from a . I had thought he might have scraped it while getting in or out of bed, but I

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A 025	Continued From page 4 don't know how he got it. I don't remember if there was an incident report filed. I am not sure if an incident report was needed." Staff A confirmed that the resident was noticeably weaker, but still able to ambulate independently. A review of the incident log was completed but there was no incident report submitted concerning this resident's injury of unknown origin. On at 3:15 PM, the Administrator stated she had reviewed the Incident Reporting policy and agreed that an Incident Report should have been completed for an injury of unknown origin. The Health and Wellness Director also agreed at this time, and she stated staff would be inserviced to ensure they understood when an incident report was required. On . . . . . , the resident was admitted to Hospice. On , the Administrator was notified via email of the amendments to the findings of the complaint conducted on . Class III	A 025		