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 _____	R 07/17/2020

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 revisit to Complaint Investigations 2019019650, 19209 and 2020001347 was conducted at The Brookshire on , and . Deficiencies were found to be uncorrected at the time of the survey.	{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 . . . . . or . , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . 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	{A 025}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 025}	Continued From page 1 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: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews, the facility failed to follow a health care provider's medication order for 1 of 8 sampled resident's (#11). Findings: Resident #11's current 1823 health assessment form, dated [redacted], indicated that he requires assistance with self-administration of medications. (photographic evidence obtained.) Review of his [redacted] Medication Observation Record (MOR) revealed an entry for [redacted], 10 milligrams (mg) by [redacted] every six hours and was scheduled to be given at 12 a.m., 6 a.m., 12 p.m. and 6 p.m. (photographic evidence obtained.) However, review of the prescription label on the	{A 025}		

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{A 025}	Continued From page 2 medication package, dated . . . . , indicated the medication was to be given as needed. (photographic evidence obtained.) The . . . . . count sheet for the medication indicated the medication was to be given as needed. (photographic evidence obtained.) A health care provider's medication list, dated , indicated the medication was to be given as needed. {photographic evidence obtained.) Review of the resident's record revealed it did not contain an order from a health care provider to give the . . . . . routinely. At 12:55 p.m. on . . . , the director of nursing confirmed the findings and said she called the pharmacy during the survey but they too said the only order on file was to give the medication as needed. Class III	{A 025}		
{A 030} SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure	{A 030}		

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{A 030}	Continued From page 3 for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation.	{A 030}		

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{A 030}	Continued From page 4 Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents 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. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate	{A 030}		

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{A 030}	Continued From page 5	{A 030}		

living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of

{A 030} Continued From page 6 {A 030}

medications, assistance in making
for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The

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{A 030}	Continued From page 7 notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for	{A 030}		

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{A 030}	Continued From page 8 the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on review of resident grievances and interviews, the facility failed to ensure that each resident was treated with consideration and respect and with due recognition of personal dignity by failing to address concerns of inappropriate treatment from the administrator towards 5 of 13 sampled residents and failed to honor resident rights by interfering when 1 of 15 sampled residents requested the assistance of law enforcement. Findings: At 12:15 p.m. on . . . , resident #17 said the administrator was a bully and some residents were afraid of her. The resident said the administrator called him a liar and she threatened to throw residents out if they contact outside agencies. At 1:30 p.m. on , resident #16 said he spoke with the administrator about concerns he had but "she just looks at you like you're stupid" and said the administrator talked down to residents. At 2:13 p.m. on , resident #15 said the administrator was not friendly, had a bad attitude and yelled at the residents anytime they spoke with each other.	{A 030}		

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{A 030}	Continued From page 9 At 2:40 p.m. on [redacted], resident #18 said the administrator was verbally intimidating, she threatened to kick residents out and said if she finds out who reports her, she will discharge them. At 3:38 p.m. on [redacted], resident #18 said she reported the administrator's behavior to corporate in [redacted]. She was provided a confirmation number and had not heard from anyone. The resident said the administrator was rude and threatening anytime residents contact the ombudsman or AHCA. At 11:25 a.m. on [redacted], resident #17 said he called corporate a couple of months ago about the administrator's threats, he was transferred to a complaint line and had not heard from anyone. At 11:33 a.m. on [redacted], resident #16 said he called corporate approximately three weeks ago regarding the administrator and was told the call would remain confidential. He said five minutes later the administrator came to his room, told him not to call corporate and said anyone who did would be given a 45-day discharge notice. At 11:43 a.m. on [redacted], resident #19 said the administrator talked down to the residents, said she'll never get fired and told the residents that if they talk to the ombudsman or AHCA they will be given a 45-day discharge notice. At 12:57 p.m. on [redacted], the corporate operations director said she was the administrator's supervisor. She said she knew residents complained about the administrator and she believed some of those residents were difficult, but she also believed the administrator	{A 030}		

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{A 030}	Continued From page 10	{A 030}		

could soften her approach. She said human resource was investigating the concerns against the administrator.

At 4:20 p.m. on , the corporate vice president said she too was the administrator's supervisor. She said several anonymous complaints had been received by corporate regarding the administrator's treatment of the residents. She investigated the complaints by speaking with department heads who had been present during meetings and they all said the allegations were not true. She said although the complainants were anonymous, she could determine who the residents were based on their complaint. She said the administrator was trying to make changes, but the same residents were going against the changes. She did not interview any residents as part of her investigation into the allegations and did not know whether anyone else had either.

Review of a corporate complaint document, dated , revealed an anonymous complaint was received regarding the administrator's behavior towards the residents. The report indicated it was the third complaint from the residents and it did not contain documentation to indicate any residents were interviewed as part of the investigation. (photographic evidence obtained.)

Review of the facility's documented resident grievances revealed no documentation to indicate residents were interviewed to determine the validity of the complaints against the administrator.

Review of the facility's policy on resident , neglect and , , dated , revealed that as part of its investigation into alleged ,

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{A 030}	Continued From page 11 statements will be taken from the victim. (photographic evidence obtained.) At 3:55 p.m. on , resident #12 said he told resident #19 to leave resident #18 and her dog alone. He said resident #19 then used her walker to ram into his right site. He called the police but nurse HH cancelled the call. He provided a copy of a grievance, dated , in which he reported to the facility that resident #19 hit him with her walker and he said he gave the grievance to the administrator. (photographic evidence obtained.) At 4:05 p.m. on , nurse HH said both resident #12 and #18 called the police, she could not remember the date, to report resident #19's actions. She said law enforcement responded to the facility. She said both resident #12 and #18 called law enforcement again for the same thing but later in the evening. She said a police officer called her and asked her what she wanted the police do about it and since she spoke with the residents who were involved and believed the situation was resolved, she told the police not to respond to the facility. At 1:08 p.m. on , the DON said that on resident #12 told her that resident #19 rammed him with her walker so she assessed his . She said she did not know nurse HH cancelled a police call made by resident #12. At 1:20 p.m. on , the DON said she called the police station today and confirmed that nurse HH did, in fact, cancel the police call resident #12 made on . She also provided a copy of resident #12's grievance form regarding the situation and said she found it on the administrator's desk.	{A 030}		

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{A 030}	Continued From page 12 Class III	{A 030}		
{A 032} SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being	{A 032}		

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{A 032}	Continued From page 13 assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observations, record reviews and interviews, the facility failed to make a daily effort to ensure 1 of 1 sampled resident (#13,) who was identified as an elopement risk, had identification (ID) on their person that includes their name and the facility's name, address, and telephone number.	{A 032}		

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	AL11932514	A. BUILDING: _____ B. WING _____	R 07/17/2020

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 032}	Continued From page 14 Findings: At 9:18 a.m. on [redacted], nurse GG identified resident #13 as an elopement risk. At 11:35 a.m. on [redacted], observations made of resident #13 with nurse GG revealed he did not have ID on his person. Nurse GG said he removes it. At 11:40 a.m. on [redacted], a request was made of the director of nursing to provide documentation to indicate the facility made a daily effort to ensure the resident has ID however, she was unable to do so. Resident #13's current 1823, dated [redacted], indicated that his diagnoses included [redacted] and he was an elopement risk. (photographic evidence obtained.) Review of his record revealed facility documentation that indicated he was exit seeking on [redacted] and the record did not contain documentation to indicate the facility made a daily effort to ensure he had ID on his person. (photographic evidence obtained.) Class III	{A 032}		
{A 084} SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the	{A 084}		

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{A 084}	Continued From page 15 self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored	{A 084}		

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{A 084}	Continued From page 16 tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training,	{A 084}		

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{A 084}	Continued From page 17 must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse, a licensed pharmacist, or agency staff. The agency shall establish by rule the minimum requirements of this additional training. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on personnel record reviews and interview, the facility failed to ensure 1 of 2 sampled staff (BB) who assisted with self-administration of medications obtained the initial 6 hour training on providing assistance with the self-administration of medications. Findings:	{A 084}		

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{A 084}	Continued From page 18 Review of staff BB's personnel record revealed a 6-hour certificate of training, issued by an online course and dated , on the topic of assistance with self-administered medications. (photographic evidence obtained.) However, there was no documentation to indicate the training included a return demonstration by staff BB to indicate she acquired the skills necessary to provide assistance with self-administered medications. At 3:12 p.m. on , staff BB said the online class was live, she completed an exam during the class and said she did not perform a return demonstration of the skills taught during the class. At 3:43 p.m. on , the nurse instructor of the class said the online class consisted of a live lecture, a proctored exam and a return demonstration conducted by herself and not by the participants. At 4 p.m. on , the director of nursing provided a , medication observation record (MOR) for resident #14 and identified the initials on as those of staff BB, which indicated staff BB assisted the resident with medications. (photographic evidence obtained.) Class III	{A 084}		