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
	AL11964946	A. BUILDING: _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MELBOURNE	1765 WEST HIBISCUS 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 #2021006271 was conducted on [redacted] and [redacted]. Brookdale Melbourne had deficiencies at the time of the visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of 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 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	A 025		

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A 025	Continued From page 1 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. (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 observations, record reviews and interviews, the facility failed to provide adequate supervision and failed to provide care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for [redacted] and injuries for 3 of 8 sampled residents who experienced repeated [redacted] and injuries of unknown [redacted] (#1, #2 & #3). Findings: 1. Review of resident #1's record revealed a facility admission date of [redacted]. An 1823 health assessment form, dated [redacted], indicated the	A 025		

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A 025	Continued From page 2 resident's diagnoses included , , and type 2. The resident resided in the facility's memory care unit. Review of the resident's record revealed documentation of the following: On at 6:08 a.m., night shift staff noted and a above the resident's right . The resident also dug her nails into another resident's left and caused a . On at 9:39 a.m., a late entry note indicated that a home health nurse saw the resident and said the facility was denying the resident the attention she needed. On , the resident had a , and it was documented there were no injuries. On in the morning, staff reported the presence of and to the resident's right of unknown origin. On , the resident had a . The home health nurse saw the resident that day and saw a on the resident's upper right that was green in color and a bump and to the ; the nurse said the facility wasn't doing anything for the injuries. The advanced practice registered nurse (APRN) was present at the facility on the previous day, saw the resident, and ordered physical and , . The home health nurse and the resident's spouse wanted the resident sent to the hospital. Emergency Medical Services ( ) was called and she was sent to the hospital. This note was signed by the Health and Wellness Director (HWD). On at 3:50 p.m., the resident was sent to the emergency room (ER) for evaluation of a right	A 025		

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A 025	Continued From page 3 injury of unknown origin. On , an update from the hospital reflected that the resident was admitted to the hospital with a diagnosis of . On , the resident's spouse would be at the facility on and to remove the resident's belongings. A facility shift report, dated , indicated that another resident hit and pushed resident #1 and that resident #1 had a black and blue area on her right forehead. An APRN note, dated , indicated the resident's right was and and she had a large hematoma around her right , especially over the . A hospital ER clinical note, dated , indicated the resident presented with yellow on her right temple, her right forehead and right periorbital area. A computerized ( ) of her revealed right periorbital soft tissue /hematoma (a solid of clotted within the tissues). On at 10:41 a.m., caregiver E said she saw and on resident #1's but she could not remember the exact date. Caregiver E said her interventions for resident #1 were to try to get the resident to the safest place possible, when the resident called for help, she assisted her, brought her out to eat, showered her on the scheduled days, and always helped the resident in every way. On at 10:48 a.m., caregiver F said she could not remember the exact date, but she saw	A 025		

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A 025	Continued From page 4 one of resident #1's [illegible] and [illegible]. The caregiver never saw the resident or hit her [illegible] in some other way to have caused the injury. Caregiver F said her interventions for resident #1 were to place the resident's locked wheelchair (w/c)next to her bed, check on her, and assist her to the bathroom. She also involved the resident with activities. She said the resident was good about staying in her w/c during her shift. On at 11:02 a.m., nurse G said she sent resident #1 to the hospital on [illegible] (approximate date) because the resident had a black [illegible]. The nurse said the resident's dresser and bed posts were both the same as the resident's [illegible] so perhaps she struck her [illegible] on either one of those. The nurse said the resident's gait was unsteady. She said the resident's family assumed she and were upset they were not told of the [illegible]. On [illegible] at 1:15 p.m., the home health nurse said she saw resident #1's right was [illegible], and she had an "Emu egg-sized knot" on the right side of her . The nurse spoke with the health and wellness director (HWD) who told her she did not know anything about the resident's injuries. The home health nurse said she told the facility staff that they needed to send the resident to the hospital for an evaluation of her [illegible] injuries. On [illegible] at 2 p.m., caregiver H said she saw another resident swat at resident #1's left arm, then push the resident one time. The caregiver intervened and did not see any injuries on resident #1. The other resident said resident #1 bit him. The caregiver said she told another caregiver what happened during shift change report. She did not see any or	A 025		

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A 025	Continued From page 5 on resident #1's following the incident with the other resident. On at 2:16 p.m., the health and wellness coordinator (HWC) said she looked at resident #1's on the morning of and saw a on the residents right . She did not remember if she saw a knot. She said the resident was short and always leaned forward when she walked. The HWC said she tried to call the resident's spouse several times that morning but was unsuccessful in reaching him. On at 2:35 p.m., the HWD said her late entry note erroneously dated instead of . She said she saw resident #1's injuries at approximately 6 a.m. on . She saw a and on the resident's right . She did not see a knot on the resident's . At approximately p.m., the home health nurse came to her about the injuries, so she went to look at them again and saw the resident's was a little more and she had a dime-sized knot with yellow on her right , that was covered by hair. She said the resident was very short and leaned forward and to the right when she walked. She said the resident's spouse was present when she went to look at the injuries again. On at 2:39 p.m., an APRN said resident #1 had a large hematoma on her right . She said the resident ambulated independently and leaned to her right side. She believed the resident may have run into something. She assessed the injury after it was seen and reported to her by the staff. On at 1:27 p.m., caregiver K said he recalled seeing a fresh on resident #1's	A 025		

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A 025	Continued From page 6 one morning. He could not remember exactly what date he saw it. He said he had to previously separate her and other residents because she would approach them and begin pinching them, so he said perhaps another resident hit her, but he never witnessed this occur and he never saw her . 2. Review of resident #2's record revealed a facility admission date of . An 1823 assessment form, dated , indicated the resident's diagnoses included , , , right branch and . The form identified her as a risk. She resided in the facility's secured memory care unit. Review of the resident's record revealed documentation of the following: A health care provider's order that was dated for , ( ) and , , ( ) to evaluate and treat. On at 6:20 p.m., she had a . On at 2 a.m., she had a near her bed. Intervention was to verify safe walkways and proper fitting clothes and shoes. On at 3 p.m., she had a near her bed. Intervention was to verify safe walkways and proper fitting clothes and shoes. On at 2:38 p.m., she was observed sitting on the floor in the hall near the dining room. She said she went to sit in her w/c, and it moved. On at 4:25 a.m., she near her bed.	A 025		

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A 025	Continued From page 7 Intervention was to verify safe walkways and proper fitting clothes and shoes. On at 5:56 p.m., she was heard yelling for help from her room. She was observed lying on the floor near the of her bed. She said she tumbled out of her w/c. On at 9:50 p.m., she in her room near her bed. Intervention was to verify safe walkways and proper fitting clothing and shoes. On at 5:45 a.m., she near her bed. Intervention was to verify safe walkways and proper fitting clothes and shoes. On at 11:30 a.m., she in her room. On , a health care provider (HCP) ordered to discontinue both her , and due to multiple and frequent . On at 12 a.m., she near her bed. Intervention was to verify safe walkways with furniture placement, verify proper fitting clothing and shoes. On at 11 p.m., she near her bed. On at 12:30 a.m., she near her bed. Intervention was to verify safe walkways and proper fitting clothing and shoes. On , a HCP ordered mats. A negotiated risk agreement, dated , indicated that she had frequent and her choice to not use or remember to use her call pendant led to frequent . The facility's attempts to decrease her risk for were	A 025		

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A 025	Continued From page 8 [illegible] every two hours, [illegible] mats, lowering her bed, remind her to ask for help with transfers and continue to assist her with care as needed. She transfers herself at times. On [illegible] at 5 a.m., she [illegible] in her room. She was up and down all night. Intervention was to verify safe walkways and proper fitting clothes and shoes. On [illegible] at 11 p.m., she was found during rounds on the floor in her room. On [illegible] at 10:32 a.m., caregiver A said her interventions for resident #2 were to conduct frequent checks on the resident and said most of the resident's [illegible] were from out of her bed. She could sometimes hear the resident yell out for help so she would go in and check on the resident. She also encouraged activity involvement. On [illegible] at 11:02 a.m., nurse G said she kept resident #2 in the common areas and kept her busy with activities. On [illegible] at 3:08 p.m., the HWD said resident #2 was included in more activities, kept out of her room, increased her nap times and checking on her. 3. Review of resident #3's record revealed a facility admission date of [illegible]. An 1823 assessment form, dated [illegible], indicated that her diagnoses included [illegible], type 2, [illegible] and [illegible]. The form also indicated she had a gait disturbance, and she was a [illegible] risk. She resided in the facility's secured memory care unit.	A 025		

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A 025	Continued From page 9 Review of the resident's record revealed documentation of the following: On at 6:30 a.m., she near her bed. A home health aide was sleeping in a chair at that time. She had a one-on-one sitter hired by her family for her 14-day . On at 5 p.m., she in the hallway. She was combative. A hospital ER clinical note, dated , indicated she was seen for possible COVID exposure. On , she arrived at a special isolation unit set up at a sister facility. On , she returned to this facility from the sister facility. On at 3:31 p.m., she had increased , most afternoons. was ordered to be given in the afternoon. On at 3:52 p.m., she was found sitting on the floor of another resident's room yelling "help me up". On at 3:10 p.m., staff observed her walking in the hallway, and she stumbled and into a closed door headfirst and landing on the ground. She sustained redness/ and an on her right forehead. She complained of , Emergency Medical Services ( ) was called and she was transported to the hospital. A hospital discharge document that was dated indicated she was seen for a closed	A 025		

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A 025	Continued From page 10 injury, . . . , ... and . . . . . of the left . On at 8:20 p.m., she returned from the hospital. On . . . . , physical and occupational therapies were ordered for gait/balance. On at 7:19 p.m., she was ambulating in the hallway when staff heard a noise and turned and observed the resident lying on her left side on the floor. She immediately got herself up and off the floor On at 4:45 p.m. she complaint of right , and right . . , . while trying to stand and she was unable to walk. Staff sat with her to maintain her safety. An APRN was notified. She was sent to the hospital. Staff reported that she was observed on her . . . in front of her chair in her room and got herself off the floor at approximately 3:05 p.m. A hospital ER clinical note indicated she was seen for a . On at 4 p.m., she returned from the hospital. On . . . . at 9 a.m., she was found on the floor by her bed. She was assisted off the floor and to the bathroom. On . . . . . , and . and a . . . , . were ordered due to recurrent . On , staff spoke with the resident's family member about the frequent . ., getting up and down and requiring more one on one attention and that perhaps the resident needed a higher level of care. It was explained to the family that	A 025		

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A 025	Continued From page 11 the facility wanted to try and rule some things out before getting to that point. On at 3:20 p.m., staff reported that she would not sit still, that she was up and down in the w/c and had to be continuously redirected. On at 1:40 p.m., staff observed her lying on her left side in her doorway. She had been in bed. She said she hit her . Her family declined a hospital visit. On at 4:47 p.m., she continued to get up and down from her w/c and she was redirected. She remained unsteady on her and a risk. Would continue to monitor her. On at 12 p.m., she was restless. She did not sit for more than a minute at a time, repeatedly stood up, walked without staff assistance; her gait was unsteady, and she needed constant redirection. She was monitored by staff while awake and for safety. She had which had minimum to moderate effect. She was encouraged to ambulate in common areas as much as possible for staff visualization for safety. Several attempts were made to engage her in activities but only lasted for short time due to her short attention span. On , a w/c was delivered. On , she continued to be restless, and her gait was unsteady. Staff provided constant redirection and she was medicated with fair effect. On at 2:30 p.m., she while walking in the hallway. Intervention was to verify safe walkways and proper fitting clothes and shoes.	A 025		

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A 025	Continued From page 12 On at 9:45 a.m., she she while walking with her w/c and hit her . She was sent to the ER via . A hospital discharge note, dated , indicated she was seen for a , closed injury, , and closed of , . Instructions were to remove in the next days. On at 9:07 p.m., staff spoke with her family member to inform her the resident was still up and down, still not sitting down and was a risk. A new order was received to increase , an , medicine, to 50 milligrams three times a day and to watch her. On , she had stitches above her left that were dry and intact with to her right . She continued to get up and down from her w/c and try to walk. Her gait was unsteady. An APRN was to see her next week and and skilled nursing from home health were to see her that week. On , she continued to ambulate about the unit and staff continued to follow her for safety. On , she was discharged from . On at 7:46 p.m., staff observed her walking in the hallway pushing her w/c as she lost her balance and onto the floor. On at 12:57 p.m., the HWD spoke with the resident's family, home health staff and an APRN about the stitches still in place in the resident's forehead. Awaiting call .	A 025		

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A 025	Continued From page 13 were placed on [redacted] and were to be removed in [redacted] days. As of [redacted], the sutrues have been in place for twenty-two days. On [redacted] at 10:53 a.m., the resident was observed walking in the hallway with a staff member. She had four [redacted] on her left [redacted]. There was no signs and symptoms of [redacted]. On [redacted] at 1:55 p.m., the HWD said she knew that when the resident returned from the hospital on [redacted] that she had [redacted] on her [redacted]. She said the resident's family approached her today and asked her when they would be removed. The HWD said she called the APRN today, who said she would send an order to the home health agency to have their staff remove them. On [redacted] at 2:04 p.m., the HWC said she believed she contacted the APRN when the resident returned with [redacted] to discuss the removal of them, but she could not remember when the discussion took place or what the APRN's response was, and she confirmed there was no documentation of the discussion. On [redacted] at 2:32 p.m., the resident was observed walking in the hallway alone and without an assistive device. At times, she used the rails on the wall. She wore tennis shoes. Her pace was fast, and her gait was shuffled. She went into another resident's room and laid down on that resident's bed. On [redacted] at 2:38 p.m., caregiver A said her interventions for the resident were she tried to keep the resident in the common areas to watch her and she reminded the resident to use her walker. If the resident appeared tired, she	A 025		

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	AL11964946	A. BUILDING: _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 025	Continued From page 14 assisted her to bed and frequently checked on her. She also tried to get the resident to participate in activities. On at 2:42 p.m., caregiver B said she redirected the resident to safe areas, toileted her as often as possible and kept watch over her. The surveyor observed caregiver B retrieve the resident's walker, assist the resident down to her own room, then assist the resident to lie in her own bed. On at 2:46 p.m., caregiver C said she followed the resident around and if the resident was sleeping, the caregiver just let her be. She put the walker in front of the resident, but she left it behind. She also gave the resident constant reminders. On at 2:49 p.m., caregiver D said she followed the resident when she walked. Sometimes she laid the resident down and sat with her. She said the resident carried the walker rather than placing it on the floor, so the caregiver reminded her on its proper use. On at 10:38 a.m., the resident was observed in her bed. Her were closed, and she was covered up. The remained in her left . Her walker was not in her room but was found on the outside patio by caregiver A. On at 10:48 a.m., caregiver F said got the resident to use her wheelchair and when she saw the resident carrying her walker, she reminded the resident to use it the proper way. She said the resident eventually became tired, so she assisted the resident to bed.	A 025		

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A 025	Continued From page 15 On . . . . at 11:02 a.m., nurse G said she provided constant redirection to the resident and retrieved the resident's walker when she was not using it. On at 3:08 p.m., both the administrator and the HWD said . interventions for resident #3 included lab work, talking with her family about transferring her to a higher level of care if the . . continued, and staff education on night checks. Class II	A 025		
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	A 032		

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A 032	Continued From page 16 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 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.	A 032		

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A 032	Continued From page 17 This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to make a daily effort to ensure 1 of 8 sampled residents, identified as an elopement risk, had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#3). Findings: Review of resident #3's 1823 assessment form, dated . . . . , revealed her diagnoses included . The form also indicated she was an elopement risk. She resided in the facility's secured memory care unit. On at 3:46 p.m., resident #3 was observed walking with her walker and with caregiver E by her side. The resident did not have ID on her person. This was checked and verified by the caregiver, who also said she was never told the resident should be checked daily for ID. On . . . . . at 3:48 p.m., caregiver C said she was never told to check elopement risk residents for ID. The resident's record did not contain documentation to indicate the facility made a daily effort to ensure resident #3 had ID on her person. The facility's "Resident Elopement" policy, last revised , indicated "residents identified as at risk for elopement should be checked daily to determine the presence of their arm ID. If during the daily check, the resident is not wearing his or her ID, it should be noted in the resident's record."	A 032		

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A 032	Continued From page 18 On . . . . . at 3:58 p.m., the administrator confirmed there was no documentation to indicate staff made a daily effort to ensure resident #3 had ID on her person since. Class III	A 032		