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
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 Limited Nursing Services (LNS) Monitoring survey was conducted on [redacted] at Brookdale Jensen Beach. The facility had a deficiency identified at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

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
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 1 who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a [illegible], [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010		

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
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate monitoring and communication regarding the resident's condition and response to required services. This was evidenced by the failure to follow the facility third party provider procedure for the coordination and oversight of third-party services for 1 of 1 sampled residents, (Resident #1) who was being treated for a , developed an additional , and had a decline in wellness resulting in loss. The findings included: Review of Resident#1 medical record indicated the resident was admitted to the facility on . Review of the current Resident Health Assessment form 1823 dated indicated the resident had diagnosis including , , , and . The assessment indicated that the resident required personal hygiene care and verbal cueing for frequent toileting. The resident was ordered a regular diet and documented admission . The assessment form further indicated that the resident was independent for eating, required supervision with ambulation with walker, , self-care, toileting, transfers, and assistance with bathing. Resident #1 did not have any , on admission. Resident #1 resides on the Memory Care Unit of the facility. Further resident record review revealed no updated 1823 Resident Assessment for Resident #1 which accurately reflects the resident's current medical condition and treatments being provided to the resident.	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 5 Resident #1 was admitted to Hospice services on [illegible] with the primary diagnosis of [illegible] along with malaise, [illegible] and [illegible] of the right [illegible] and several [illegible] on the [illegible]. Review of the hospice assessment indicated that the resident had functional limitations, including ambulation, [illegible] and [illegible], endurance and speech. The resident's mental status was documented as oriented to person, [illegible] and forgetful. Resident #1 has a history of poor appetite and on average will consume 15- 25% of 3 child size meals daily and requires facility staff to assist/ coax her to eat. She drinks 1 carton of Ensure daily. Resident #1 is documented as weak, non-ambulatory, non-[illegible], and confined to bed or high [illegible] wheelchair. The resident requires total assistance with bed baths, bed mobility, [illegible], toileting, wheelchair mobility, transfers, meals and medications. Resident #1 is documented as a high [illegible] risk due to prior [illegible] history. Review of the hospice Nursing Notes indicated that the hospice Nurse instructed the facility Nurse and Caregiver to reposition the resident every 2 hours to prevent further [illegible]. Review of the hospice Nursing Note dated on [illegible] indicated the [illegible] was documented as having yellow eschar and small amount of drainage. New [illegible] care orders were requested, and a low air mattress and hospital bed were ordered. The hospice nurse documents that she instructs the facility staff and nurse to reposition Resident #1 every 2 hours. Review of the hospice Nursing Note dated [illegible] documented the right [illegible], [illegible] is	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 6 . . . . . The facility nurse was informed of the resident's and decline along with poor appetite. Review of hospice Nursing Note dated indicted that the right , ... was draining and required an unscheduled hospice nursing visit to perform care. The facility Nurse was notified of the . . . care treatment and observation of the . On . . . . . , Resident #1 is documented as having no appetite and requiring staff assistance to eat, with very poor intake of meals. The note further indicated that Resident #1 continues to decline. The hospice nurse documents that resident condition and care was discussed with the facility staff including care, , management and overall decline. Review of hospice Notes from until . . . . . indicated the right , ... initially measured at 7.5 centimeters (cm) x 3 cm x 2 cm, and with healing measured 1.5 cm x 1 cm x 0.8 cm after 3 x week hospice care visits. Review of the hospice Note on . . . . . indicated that during care the hospice Nurse observes a new , ... on Resident #1's , , . The Note indicated that the new observation was discussed with the facility Nurse, and Care staff. The hospice Nurse instructed facility staff to reposition Resident #1 every 2 hours and apply . . . to the . . . . , also a pressure , . . . was also recommended for the resident's wheelchair. Review of the facility Nursing Note dated . . . . . indicates development of . . . , , and to reposition resident every 2 hours. Review of subsequent Notes revealed no documentation of compliance that repositioning of	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 7 Resident #1 was routinely being performed as per hospice instructions. Review of the hospice Note dated the Nurse documents that Resident #1's is now progressed to a care was performed on the . The hospice Nurse documents that she notifies facility Nurse and Care Giver and instructed to reposition resident every 2 hours. Review of the hospice Noted dated indicated that the is draining a small amount of drainage. Further review of the Notes on indicated the had healed/ resolved. In an interview conducted with Resident #1's hospice Nurse on at 1:30 PM, she stated that Resident #1 has a diagnosis of and . The Nurse stated that care/ support was being provided to Resident #1 and that overall, she was declining. The nurse stated that she was treating Resident #1 for a on the right , and recently ended treatment of a resolved of the . She stated that Resident #1 had nutritional due to poor appetite even with facility staff assisting the resident to eat. The Nurse stated that the resident had lost over since her admission to the facility. The Nurse stated that the resident was bed bound, requiring total care for all ADL (activities of daily living) care. She stated that Resident #1 was admitted to the hospice service with the right , , which had slowly been healing, even with the nutritional . She stated that Resident #1 had developed a to her , going from a to a and it had	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 8	A 010		

healed/resolved. She stated that due to Resident #1's overall health decline, further [illegible] is very likely. She stated that she completes the facility "Home Health/Hospice/ Third Party Provider Collaboration Notes" on each visit to see Resident #1. As instructed by the facility, she [illegible] the completed form to the facility floor Nurse and will also verbally discuss the treatments performed and any new observations at that time. The hospice Nurse was asked what instructions she had given to the facility Nurse and staff regarding Resident #1, she stated she instructed them to reposition the resident every 2 hours to facilitate [illegible] healing and reduce potential [illegible]. She stated that she does not communicate with the Health and Wellness Director about Resident #1's condition and care needs.

Review of the hospice Physician Certification Summary dated [illegible] indicated that Resident #1 has a [illegible] diagnosis. The resident is confined to bed or high [illegible] wheelchair and requires total assistance with all ADLs. The resident has very poor appetite and consumes 15-25 % of 3 child size meals a day and drinks one Ensure. The resident's [illegible] on admission was [illegible], and currently the resident [illegible]. The resident is frail, thin, and cachectic with [illegible] wasting. The resident has a healing [illegible], on the right [illegible], and remains a high risk for further breakdown due to [illegible], fragile skin, immobility, and compromised nutrition. The resident continues to decline in function secondary to her progressive [illegible] process.

In an observation of Resident #1 on [illegible] at approximately 2:00 PM, the resident was lying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 9 in her hospital bed on her left side. She was thin, and frail. Her body was supported by a long body pillow to prevent the resident from falling forward. Resident #1 responded to her name and stated that she was comfortable, having no , . when asked. In an interview with Resident #1's Caregiver on . . . . . at approximately 2:05 PM, she stated that she worked the day shift and regularly cared for Resident #1. She stated that the resident care she provides includes getting the resident dressed, and transferring her out of bed, which required 2-person assistance, to the high wheelchair. She stated that Resident #1 required total assistance for her ADLs, and that the resident had declined in strength, was . . . . . and very weak. When asked about repositioning Resident #1 as instructed by the hospice Nurse, the Caregiver stated that throughout the day she transfers Resident #1 from bed to wheelchair for meals then to bed for afternoon rest. The Caregiver also stated that Resident #1 is of and . . . . . and needs to be checked and changed frequently. When asked if the Caregiver documents the care she provides to Resident #1, she stated she does not. She stated that she was unaware of any mechanism to document the turning/ repositioning the resident as instructed by hospice. She confirmed that she had had direct communication with the hospice Nurse and was following the Nurse's instructions. In an interview conducted with the Health and Wellness Director, RN on at approximately 12:45 PM, she stated that she was not responsible for, and did she get directly involved with resident care, but the Licensed Practical Nurse (LPN)/ Floor Nurse is responsible	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 10	A 010		

for the residents. She stated that she was providing no oversight for the resident's care and services. She stated that there was one Nurse scheduled daily whose responsibility was to cover resident nursing needs for the entire facility. She stated that her expectation was that the Floor Nurse should inform her of any resident nursing concerns. She stated that she had not observed any care for Resident #1 performed by the hospice Nurse and had no personal knowledge about the status, stating that would be the responsibility of the Floor Nurse. When questioned about the resident's loss, the Director could not provide specific knowledge about the resident's condition. The Director stated that she had not been notified of Resident #1's additional development. When asked about the facility policy for 3rd party providers she stated that with each visit the provider staff should complete the "Home Health/Hospice/ Third Party Provider Collaboration Notes" and then communicate directly with the Floor Nurse on duty. She further indicated that her expectation was that the Nurse should review the 3rd party provider written note, then sign and date the form. She stated that the form will be placed in the resident's record. The Director stated that she does not review the communication sheets but relies solely on the Floor Nurse to review and to notify her with any concerns. The Director stated that currently there are 37 residents receiving 3rd party provider nursing services from Home Health and Hospice providers.

In an interview conducted with the Administrator on at approximately 2:30 PM, she stated that the facility does not have a written 3rd party provider Policy/Procedure. She stated that current staffing for the facility includes one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964787	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE JENSEN BEACH	1700 NE INDIAN RIVER DRIVE JENSEN BEACH, FL 34957

(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 010	Continued From page 11 Licensed Practical Nurse (LPN)/ Floor Nurse on duty daily, usually for a 10-hour shift and responsible for the entire building. The census on was 101 residents. The Administrator stated that the Director is always on call for assistance. The Administrator stated that her expectation is that the Floor Nurse communicates 3rd party provider observations/ recommendations to the Director. The Administrator stated that the facility has a daily morning staff stand-up meeting to discuss any issues and has a biweekly meeting to discuss and address specific concerns with residents. The Administrator stated that she had concerns that the facility policy for 3rd party provider Policy was not being followed by facility staff and that the Director was not informed of resident care concerns as expected. Class III	A 010		