STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965569	12/15/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brookdale Boca Raton	9591 Yamato Road Boca Raton, FL 33434	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced licensure complaint surveys for CCR#s 2014011909 was conducted on . . . . to . . . . at Homewood Residence Boca Raton assisted living facility. The facility was not in compliance during this visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, interview and record review the facility failed to adequately provide care and services appropriate to meet the needs of the residents by not properly assessing, monitoring or supervising them and did not promote the safety and physical well-being of 4 out of 6 at-risk residents (residents #2, 4, 5 and 6).

The findings include:

Review of resident #2 ' s record indicated that she was admitted to the facility on . . with diagnoses including Parkinson ' s . . . . history of . . and left hip . . . . . Review of her Health Assessment dated on . . indicated that the resident was alert and oriented with . . and required one person supervision for ambulation, bathing, dressing, toileting and transfers.

Review of the facility ' s . . . risk policy and procedure (as attached) indicated that the residents must receive a facility-specific risk identification evaluation (RIE) upon admission, change of condition and every six months thereafter. This policy and procedure described that the residents must receive the RIE at the same times as when the residents received a facility-specific personal services assessment . Further review of this policy and procedure indicated that every resident with an identified . . . . risk must have individualized interventions listed in their . . . . This policy and procedure indicated that after a

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resident ..... event, the facility must complete a post .. investigation (PFI) to determine if any resident ' s ..... risks have changed and/or their interventions need to be updated.

Review of resident #2 ' s PFI dated on .. . indicated that the resident was found on the floor in her ..... 8:45AM and the resident had apparently lost her balance. Further review of this PFI indicated that the secondary evaluation had not been completed.

Review of resident #2 ' s PFI dated on ..... indicated that the resident was found on the floor in the main lobby area at 9:00AM and the resident was unable to describe the ... details. This PFI indicated to ensure resident walkways are clutter free and safe, to make a physical .. . referral for safety awareness, to remind the resident to use her assistive device, and to increase frequency of monitoring by staff. Review of the facility Incident reports log dated on .. . indicated that the resident was sent to the hospital for evaluation of a head injury after this .....

Review of resident ' s #2 PFI dated on ... indicated that the resident was found on the floor in the Dining ..... 9:30AM, the resident stated she had lost her balance. This PFI indicated that the resident must continue receiving .. ' services and the staff must remind the resident to utilize her walker. Further review of this PFI indicated that the resident ' s risk factors were due to a change in medical .. status and recommended increased frequency of resident monitoring.

Review of resident #2 ' s PFI dated on .. indicated the resident .. in her ..... 11PM and was unable to recall the details of the .... An evaluation at this time found that the resident had a recent change in her health care status and was not using her assistive device or the call light to summon for staff assistance. This evaluation updated the resident ' s interventions to include continuation of .. ' services, to educate the resident on use of call light system, to use a night light in the resident ' s .... to use a wheelchair for ambulation. Review of the residents ' Personal Service Plan dated on ..... indicated that the resident required use of a walker as a mobility aid, the facility staff must remain alert of the resident ' s .... risk and the resident was independent with ambulation to and from the dining ....' community activities. Further review of the resident ' s record revealed no documentation to accurately reflect how the facility implemented any ..... prevention interventions to reduce the resident ' s ..... risk in consequence of her documented ....

Review of resident #2 ' s PFI dated on indicated the resident was found on the floor in her ..... 11:20AM, after losing her balance while reaching for an object and she was not utilizing her assistive device at the time. Further review of this PFI indicated that the facility discussed with the resident ' s

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representative a recommendation for the resident to receive a private duty aide (PDA) and for ... services to assist with her gait. Review of the Risk Identification Evaluation (RIE) dated on ... indicated that the resident had a history of ..... in past 12 months which resulted in injuries, required an assistive device(walker) and was unsteady when ambulating without the device and she was reluctant to use the walker. Further review of the resident ' s record indicated that there was no additional documentation regarding this ... any staff interventions implemented after the ... or any contact with the resident ' s physician to discuss her ..... risk and history.

Review of resident ' s #2 PFI dated on ... indicated the resident was found on the floor in her ..... 2:00 AM, she stated she was attempting to ambulate to the ... Review of the RIE dated on ... indicated that the resident had a history of ... with injuries and the resident ' s reluctance to call for assistance and her apartme ... identified as potential environmental risk factors. Review of the Nursing Progress note dated on ... at 10AM indicated that the resident had no apparent injury after this ... and her family and physician were notified.

Review of resident #2 ' s PFI dated on ... indicated the resident ..... in her ..... 1:50PM, while bending to reach for an item. Review of the Progress Note dated on ... indicated the resident had no apparent injury and did not complain of pain after this ... and her representative and physician were notified. Review of this note indicated that the resident was assisted to her feet by the staff and was instructed to call for assistance. Further review of the resident ' s record indicated that no RIE was completed after this ..... and there was no additional documentation to reflect the facility ' s interventions implemented after this ..... or any contact with the resident ' s physician to discuss her ..... risk and history

Review of resident #2 ' s PFI dated on ... indicated the resident ..... in her ..... 3:30PM and the resident stated that the "walker got in her way" and " she had hit her head " . Review of the Progress notes dated on ... indicated the resident was sent to the hospital for evaluation of her head injury and returned from the hospital that same evening. Review of the resident ' s record indicated that no RIE was completed after this ... Review of the hospital discharge instructions dated on ... indicated a diagnosis of closed head injury, as a result of the ..... with a special note included to see the physician on ... for re-evaluation. Further review of the resident ' s hospital discharge Instructions indicated that the resident must rest and to ambulate only with assistance and with the walker, to ensure safety. Review of the supplemental "Head Injury" discharge instructions indicated that due to a head injury, most symptoms occur within the first 24 hours and the resident must be monitored for potentially serious warning signs and symptoms. Review of the Nursing Progress notes indicated that there was no

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documentation that the resident received any of the prescribed hospital discharge interventions when re-admitted to the facility on .

Review of resident #2 ' s PFI dated on indicated the resident was found on the floor in her 2:05PM and she stated that she lost her balance while ambulating to the . This PFI was not totally completed and a RIE was not completed after this . Review of the Progress notes dated on at 3 PM indicated that the physical found the resident on the , the facility nursing staff was notified and the resident denied hitting her head.

Review of resident #2 ' s PFI dated on indicated that the resident was found on the floor in her 8:15PM. This PFI identified the resident ' s change in medical condition and noncompliance with safety interventions as potential risk factors. Review of the resident ' s record indicated that no RIE was completed after this . Review of resident ' s Progress notes dated on indicated that the facility staff had spoken with the resident ' s representative about her frequent and discussed recommendation to increase the resident ' s PDA hours from 12 to 24-hours, around the clock, to provide ADL care.

Review of the facility Incident Reports Log indicated that from resident #2 ' s admission on to present on , she had 14 times and sustained injuries on 5 of those 14 reported .

In an interview with the nurse supervisor on at 9:45AM, she stated that resident #2 had a long history of numerous due to her unsteady gait caused by the Parkinson ' s She stated that the resident required assistance with mobility and use of a walker for support during ambulation. She stated that the resident had become increasingly more and forgetful which required additional cueing by facility staff to use the walker. She stated that based on the numerous and change in the residents mental condition, the facility recently recommended to the resident ' s representative that a 24-hour PDA was needed to provide monitoring for the resident. She stated that the facility staff was unable to provide the increased amount time required for appropriate monitoring for the resident. She stated that it was the facility ' s responsibility to complete every RIE and PFI as per policy and procedure to ensure every resident ' s safety. She stated that she was not aware if the facility had engaged in any discussions with the resident ' s physician regarding her change in condition and ongoing history.

In an interview with the administrator on at 9:50AM, she stated that she was aware of resident #2 ' s numerous with injuries and that it was the facility ' s responsibility to complete every

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RIE and PFI as per policy and procedure to ensure every resident ' s safety and identify ongoing risks. She stated that upon her review of the facility ' s risk policy and procedures, the facility staff had not properly followed this written policy and procedures.

In an observation on at 2:30PM resident #2 was ambulating with a walker and her PDA by her side. The resident ' s gait presented to be unsteady and slow at this time and she had an area of purple-colored surrounding her left eye and left corner of her mouth. The resident stated at this time that she had recently but could not recall the details of the She stated that she had an emergency call pendant around her neck but she " forgets to use it to call for assistance " .

In an interview with resident #2 ' s physical on at 2:35 PM, she confirmed that the resident had a medical history of Parkinson ' s and had a very unsteady gait and a history of numerous She stated that resident had recently experienced a decline related to with increased forgetfulness and noncompliance with using her walker for ambulation. She stated that the resident had required 24 hour supervision with ambulation to reduce the risk of and she had brought her concerns to the facility ' s daily management meeting. She stated that she was aware of discussions with the resident ' s family regarding the need for 24 hour supervision but she was not sure what had been arranged by the facility. She also stated that it was her understanding that the facility had to perform RIEs and PFIs every time the resident had a to identify the cause of the and to develop interventions to reduce future

In an observation on at 4:00PM resident #2 was observed ambulating independently with her walker in the main lobby area, with no facility staff in the area supervising the resident. She stated at this time that her PDA had left for the day and she was on her way to an activity before going to the dining

In an interview with resident #2 ' s son on at 2:40PM, he stated that he was aware of his mother ' s history in the facility and that some resulted in injuries. He stated that he had recently noted a further decline in her mother ' s motor skills and memory and he had expressed this concern to the facility to help improve her safety. He stated that the facility recently suggested that due to the increased safety needs for monitoring of his mother, to increase the number of PDA hours from part of the day to around the clock. He stated that the facility did not discuss with him any other necessary prevention interventions besides the increased amount of PDA hours, which he was financially responsible for.

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Review of resident #6 ' s record indicated that he was admitted to the facility on with diagnoses including infarct and . Review of his health assessment dated on indicated that he had physical and sensory limitations including gait instability, poor short term memory and was hard of hearing. Further review of his assessment indicated that he needed supervision with all of his activities of daily living (ADLs), including transfers and ambulation, and medication administration. Review of the resident ' s physician progress notes dated on and indicated that he was diagnosed with gait instability and must continue with precautions. Review of the resident ' s evaluation dated on indicated that he had severe , lacked decision making capacity and required others to maintain ADLs and a safe environment.

Review of the facility ' s incident reports indicated that resident #6 on and on . Review of the resident ' s observation log dated on indicated that a facility caregiver found him on the floor, lying on his back, at approximately 12:00pm and received a bump on his head which was . This documented observation indicated that the resident was and described what had happened, and he was subsequently transported to the hospital for evaluation. Review of the resident ' s PFI dated on (as attached) indicated that he tried to get out of his chair, on the floor at approximately 12:00pm and was transported to the hospital for further evaluation. Review of the resident ' s PFI dated on (as attached) indicated that he by his at approximately 4:00pm and the secondary part of the PFI was not completed. Review of the resident ' s observation log dated on indicated that the resident ' s son voluntarily decided to discharge the resident from the facility. Further review of the resident ' s record indicated that he did not receive a RIE when he was admitted to the facility on and no precaution interventions were implemented by the facility staff after the resident ' s on .

In an interview with the administrator on at 11:05am, she stated that she has no evidence that the facility evaluated resident #6 ' s risk upon admission or change of condition, or that it implemented any actionable precaution interventions after the resident ' s on . She stated that she spoke with the resident ' s son after the resident ' s on to request an individual 24-hour, around the clock private duty aide (PDA) for the resident, since the resident required close supervision with his transfers and ambulation, and was also exhibiting combative behaviors towards the facility staff. She also stated that she used to constantly see the resident walk all around the facility during day time hours, without any staff supervision and that she was unaware of the resident ' s ADL status while the resident lived in the facility.

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Review of resident #4 ' s record indicated that she was admitted to the facility on with diagnoses including and unstable gait. Review of her health assessment dated on indicated that she needed supervision with ambulation, transferring and toileting.

Review of the facility ' s incident reports indicated that resident #4 on at 12:45pm near the facility ' s memory care unit (MCU) dining Review of the resident ' s PFI dated on (as attached) indicated that the resident was not able to explain what led to her and she was wearing open toe sandals. Further review of this PFI indicated that no interventions were considered to reduce the resident's future risk. Review of resident's RIE dated on indicated that the facility was not certain of the resident's eye sight/vision status, she was needed assistance with toileting and received benzodiazepine medications. Further review of the resident's record indicated that she did not receive a RIE after and no precaution interventions were implemented by the facility staff after the resident ' s on

In an observation on from 12:30pm to 1:00pm, resident #4 was walking independently, without direct supervision, throughout the MCU, including the common living areas, hallways and outdoor patio. Two facility caregivers were in the MCU dining this time, occupied assisting with other residents with their meals.

In an interview with resident #4's daughter on at 2:20pm, she stated that she was aware that her mother needed supervision or assistance with her ADLs and she believed that the facility was providing those services. She stated that she was informed by the facility of her mother's in 2014, but she was not provided with the details relating to the or any interventions implemented by the facility staff to prevent future

In an observation on at 4:35pm, resident #5 was walking independently with her walker in the MCU hallways and living areas without any staff assistance or direct supervision. The resident presented to be unsteady ambulating with her walker at this time.

In an interview with caregiver B on at 4:40pm, she stated that resident #5 walked around the MCU independently and she was not aware of the resident ' s assessed ADL status.

Review of resident #5 ' s health assessment dated on indicated that the resident was diagnosed with a previous pelvic and history of This

assessment indicated that she needed assistance with ambulation and transfers.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview, the facility failed to treat 1 out of 7 residents (resident #5)with consideration and respect by not allowing her to use her immediate living quarters for personal use.

The findings are:

In an observation on at 4:35pm, resident #5 was walking into her caregiver C was inside the . In an interview with the resident at this time, she stated that she wanted to go into her bed so she could rest because she felt tired.

In an observation on at 4:35pm, caregiver C told resident #5 that she may not go into her rest, because she was supposed to be in the common living area of the memory care unit until dinner was served around 5:00pm.

In an interview with caregiver B on at 4:40pm, she stated that it was procedure to not let the residents inside the memory care unit to enter their for prolonged periods of time because it made it difficult for the staff to monitor the residents.

In an interview with the administrator on at 2:40pm, she stated that it was the facility's procedure to not allow residents inside their own on their own choice, in the memory care unit because it made it difficult for the staff to assist and/or supervise the residents when the staff members were in the dining or living areas of the memory care unit.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review and interview, the facility failed to provide employee B with resident rights and

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prevention training within 30 days from initial employment.

The findings are:

Review of employee B's record indicated that she was hired by the facility on as a resident caregiver. Further review of the employee's record indicated that she received facility in-service resident rights and prevention training on

In an interview with the administrator on at 6:00pm, she stated that the facility did not have documentation that employee B received facility in-service resident rights and prevention training within 30 days of her initial employment on

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale Boca Raton
9591 Yamato Road
Boca Raton, FL 33434

RE: CCR #2014011909

Dear Administrator:

This letter reports the findings of a complaint survey conducted on , 2014 by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D

Directed Corrective Actions:

1. St - A - 0025- The facility is required to demonstrate strict adherence to its own ... Management Program" policy and procedure for monitoring the care and safety needs of all the residents in the facility, with consideration of each resident's functional ability, activity of daily living (ADL) status, physical/sensory limitations, behavioral status, supplemental service requirements and special precautions based on each of their current health assessments.

   The facility must demonstrate that each of its policy details is being met:
   Facility staff education: documentation of each direct care staff member to have received ... and accident prevention training on an annual basis.

   Resident evaluation: a risk identification evaluation (RIE) must be completed for each resident upon admission, change in condition and 6 months after.

   Resident interventions: residents identified by their physician or health care provider, as documented in their individual health assessment, to have a ... risk must receive individualized ... and accident prevention interventions shall be documented in the resident's record.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 361-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Pos: l investigations: the facility must complete the post l investigation (PFI) to determine if the resident's ...l risks have changed or interventions need to be updated. Resident ..... are to be reviewed by the facility's collaborative care review to ensure documented response to each resident ...l event.

Quality-performance improvement: resident ...l events must be tracked and trended on a monthly basis and opportunities for staff performance improvement shall be considered by the collaborative care review.

The facility must clearly describe actionable resident ...l and accident prevention interventions and must identify the staff responsible to deliver and implement said interventions during every shift. Each direct care staff member must demonstrate ongoing knowledge of their current individual service requirements to actively reduce each resident's risk for ...l and prevention of accidents.

Any resident identified by any direct care staff member to have functional abilities, ADL status, physical/sensory limitations and behavioral status inconsistent with the same resident's current health assessment or needing supplemental services and special precautions not identified in their current health assessment, must immediately be referred to their physician or health care provider for an updated examination to determine their current needs/level of care.

2. St - A - 0030- The facility must cease and desist any practices or procedures by its staff that prevents the residents from entering their own ..... and deprive the use of their own immediate living quarters as they see fit, independent of the hour in day or events held in the facility.
   All facility direct care staff must undergo an updated 1-hour resident rights training course discussing the maintenance of resident choices and allowing individual resident access to their immediate living quarters. This course must be taught by a Core-trained individual or registered nurse NOT employed by the facility or a representative of the Department of Children and Families or Department of Elder Affairs.

   The facility must observe every resident's rights in accordance to their individual care needs and if the facility finds that it cannot adequately meet any of the residents' needs, it remains the facility's responsibility to coordinate for appropriate health care including, but not limited to transferring the resident to a facility offering a higher level of care.

3. St - A - 0081- The facility must ensure that every new employee receives in-service training consistent with Florida Administrative Code 58A-5.0191.

   The facility must maintain detailed documentation to prove its staff training was conducted as per regulations and this documentation must be provided to the Agency upon request.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Brookdale Boca Raton
, 2014

Should you have any questions, please call .... Laura Manville, Survey and Certification Support Branch, at (727) 552-1955 and/or Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

Field Office Manager

Acknowledge by: Lena McKinney

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8 2015
BY:

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924