STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964787	08/10/2016
NAME OF PROVIDER OR SUPPLIER **BROOKDALE JENSEN BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 NE INDIAN RIVER DRIVE** **JENSEN BEACH, FL 34957**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Unannounced licensure complaint surveys, CCR #2016004757 and CCR #2016005927, were conducted on 18th and 5th, 8th and 10th, 2016 at Brookdale Jensen Beach (License #9294). The allegations were substantiated with deficient practice identified.

0025 Resident Care - Supervision

Based on record review and interviews, the facility failed to ensure health care providers' orders were followed, for 2 out of 5 sampled residents (Resident #4 and #5).

The findings included:

a) Resident #4 was admitted to the Memory Care Unit on . The health assessment (AHCA Form 1823) dated documented that the resident had a diagnosis of with "memory loss", and required "hands on assistance" with toileting. Resident #4's record showed a health care provider's order dated for a "UA/Urinalysis" (sample) to be collected . Review of the resident's observation notes revealed no documentation of the collection or submission of the resident's for laboratory testing. The resident was sent to the hospital on with a temperature of "101 degrees", and " all night".

During interview with the home health agency representative on at 3:00 PM, she stated that this resident's order for the UA was sent to the laboratory to be picked up within one business day. It was unkown why the sample was not obtained by the laboratory company.
During interview with the Regional Director on at 4:30 PM, she stated that the standard practice for collection of a specimen is for the ALF staff to obtain the within one day of the health care provider's order and document if unable to collect the , as well as notify the health care provider for alternative methods to collect it.

b) Resident #5 was admitted to the facility on . The health assessment (AHCA Form 1823) dated documented that the resident had diagnoses of Parkinson's , Memory Loss and Generalized ", and required "assistance" with toileting. Resident #5's record showed a health care provider's order dated for a "UA/Urinalysis" (sample) to be collected . Review of the resident's observation notes revealed no documentation of the collection or submission of the resident's for laboratory testing. The resident left the facility on , and did not return.

During interview with the Regional Director on at 4:30 PM, she stated that the standard practice for collection of a specimen is for the ALF staff to obtain the within one day of the health care

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provider's order and document if unable to collect the , as well as notify the health care provider for alternative methods to collect it.

Class III

0026 Resident Care - Social & Leisure Activities

Based on observation, interview, and record review, it was determined the facility failed to ensure that they provided an ongoing activity program at least 6 days a week for a total of not less than 12 hours per week, to include activities selected by residents and based on current residents' needs, abilities and interests.

The findings included:

The activities calendar dated 2016 that was posted on the wall in the activity (front hallway off elevator) indicated the following activities were scheduled:

Monday:
9:45 AM B-Fit
10:00 AM Scenic Tour (bus tour)
10:15 AM Catholic Services
11:00 AM Coloring Crew
1:30 PM Bean Bag Toss
2:00 PM Coloring Crew
3:30 PM Clustered Groups
6:30 PM Travel (IN2L)

Each of the activities were to take place in designated common areas of the Memory Care Unit (except the bus tour) on this date, . However, none of the activities were observed. Resident #2 was observed receiving "Catholic Services" by an individual who approached the resident at 10:30 AM, asked him to pray with her, and said a prayer out loud to the resident before leaving. During observation of residents in the common areas of the Memory Care Unit from 9:00 AM through 1:30 PM, the residents were seated in chairs or in wheelchairs in the hallway off the elevator with a small flat screen computer monitor playing children's songs and an exercise video. On occasion, one of the four staff members on the unit (Staff A, B, C and E) would talk to a resident and momentarily engage them in the computer screen. Staff E stated during interview at 1:30 PM, when an unknown person arrived to begin a word game with the residents, that she did not know who the person was that was initiating the activity. Demonstration of participation of residents in any activities on the calendar was not documented or

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observed on this date.

These findings were reviewed with the Administrator during interview on at 3:30 PM.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on record review and an interview, the facility failed to ensure staff treated residents with dignity and respect and with due recognition of personal dignity, for 1 out of 3 sampled residents (Resident #2).

The findings included:

Resident #2 was admitted to the Memory Care Unit on . The resident's health assessment (AHCA Form 1823) dated showed diagnoses including Parkinson's , and . The assessment indicated the resident required "assistance" with eating and had " ".

On / between 10:00 AM and 12:00 PM, Resident #2 was observed in the Memory Care Unit asking Staff B for "ice cream" three times. Staff B responded to each request, "No, you can't have that. You have to eat your lunch first", "You can't eat that out here (activity area with tables and chairs)" and "No you have to wait until after lunch". Staff B did not offer assistance to move the resident who was wheelchair bound into the dining area to have a snack. Staff B did not offer an alternative snack (other than ice cream). Staff B did not attempt to redirect the resident in a positive encouraging manner.

At 11:00 AM, Staff B passed out juice to the residents in the activity area. She handed Resident #2 a small plastic cup, but the resident dropped the juice on his pants while seated in the wheelchair. No other beverage was offered to the resident until lunch was served at 12:30 PM.

Staff B was asked why the residents were able to drink juice in the activity area, but not eat a snack as she had instructed Resident #2. She stated, "I don't know. They were supposed to have a snack but I didn't see it so I have them something to drink." She explained that snack is supposed to be retrieved from the kitchen on the first floor by one of the three aides working in the Memory Care Unit, but it is not designated as to who is responsible for this task.

Further observation revealed three residents were served lunch at 12:30 PM in the activity area, at the same table Resident #2 was told he was not able to eat.

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These findings were reviewed during interview with the Administrator on at 3:30 PM.

Class III

0054 Medication - Records

Based on record review and an interview, the facility failed to ensure assistance with self-administration of medication was documented on the Medication Observation Record (MOR), for 1 out of 4 sampled residents (Resident #5).

The findings included:

Resident #5 was admitted to the facility on . The resident's health assessment (AHCA Form 1823) dated showed the resident required "assistance" with medication and listed the following precriptions to be provided daily:

a) (twice a day/)
b) (three times a day/)
c) (three times a day/)
d) (twice a day/)
e) -time release (at bedtime)

Review of the resident's undated Medication Observation Record (MOR) showed the above listed medications with no intials to show when and if the resident received any of the medications during his stay at the facility from through . An observation note dated / indicating, "She (caregiver) is going to give meds until they get a new 1823. Meds are wrong on 1823." No further documentation was present to show attempts to obtain medication for the resident, attempts to obtain an accurate list of medication, or revision of the resident's health assessment to show the resident did not require assistance with medication by the facility.

These findings were reviewed during interview with the Administrator on / at 3:30 PM.

Class III

0056 Medication - Labeling and Orders

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Based on record review and an interview, the facility failed to ensure medication was filled timely, for 1 out of 4 sampled residents (Resident #5).

The findings included:

Resident #5 was admitted to the facility on . The resident's health assessment (AHCA Form 1823) dated showed the resident required "assistance" with medication and listed the following precriptions to be provided daily:

a) (twice a day/)
b) (three times a day/)
c) (three times a day/)
d) (twice a day/)
e) -time release (at bedtime)

Review of the resident's undated Medication Observation Record (MOR) showed the above listed medications with no intials to show when and if the resident received any of the medications during his stay at the facility from / through . An observation note dated / indicating, "She (caregiver) is going to give meds until they get a new 1823. Meds are wrong on 1823." No further documentation was present to show attempts to obtain medication for the resident, attempts to obtain an accurate list of medication, or revision of the resident's health assessment to show the resident did not require assistance with medication by the facility.

These findings were reviewed during interview with the Administrator on at 3:30 PM.

Class III

0079 Staffing Standards - Levels

Based on record review and an interview, the facility was found to be absent of the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents.

The findings included:

On at 9:00 AM, a random staff member greeted this surveyor and attempted to find a person in charge of the facility by calling the Memory Care Unit by a radio device. After several failed attempts to locate the Health and Wellness Director, this surveyor was escorted to the Memory Care Unit at 9:30

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AM. Staff E stated during interview at this time that she did not know if the Administrator was still employed at the facility as he had not "been seen in two weeks". At 10:00 AM, the Health and Wellness Director arrived to the Memory Care Unit and stated during interview that the Administrator had been "out for a week", and that the Memory Care Director "was ill and in the hospital, gone for over a week". When asked who was in charge of the facility, she stated "I guess I am". At 3:00 PM on , the Health and Wellness Director was asked if there was anything in writing to designate her as the person in charge of the facility's operation. She stated, "Not that I'm aware of". The facility is required to designate a person in charge and present at a facility when the administrator is absent for more than 48 hours.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

Administrator
Brookdale Jensen Beach
1700 NE Indian River Drive
Jensen Beach, FL 34957

RE: CCR #2016004757 & CCR #2016005927

Dear Administrator:

This letter reports the findings of complaint surveys that were conducted on [redacted], 2016 and concluded on [redacted], 2016 by representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than [redacted], 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

XG90

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