STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	10/13/2016
NAME OF PROVIDER OR SUPPLIER **THE BROOKSHIRE**	STREET ADDRESS, CITY, STATE, ZIP CODE **85 BULLDOG BLVD.** **MELBOURNE, FL 32901**	

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

0000 Initial Comments

A complaint investigation (CCR 2016007679) was conducted at The Brookshire (license #7354) on , and / . The Brookshire had deficiencies at the time of the visit.

0160 Records - Facility

Based on the Admission and Discharge Log review and interview, the facility did not maintain and accurate and up to date log.

Findings:

Review of the Admission and Discharge log revealed resident #1 was admitted on / and was still a current resident. Review of her closed record indicated she expired on / / and her apartment was vacated of her belongings with a final discharge date of / .

Review of the Admission and Discharge log revealed that resident #2 was admitted on / / and was discharged on / / with a reason documented as "family w/o notice." Review of his closed record indicated that he was admitted to the hospital in 2016, then transferred to a rehab facility, where it was determined that he required a higher level of care.

The administrator confirmed on / at 1:00 PM that the log was not correct. She stated Resident #1 expired and the family took the last of her personal items out of the facility on / . The administrator stated Resident #2 did not leave without notice and the family was in contact with the facility throughout his hospital and rehab stay. He has relocated to a nursing home.

Class

0167 Resident Contracts

Based on contract review, financial review and interview, the facility failed to honor the resident contract and provide a refund within 45 days of discharge for 1 of 2 sampled residents. (#1)
Findings:
Record review for Resident #1 revealed a contract dated / / which stated that a pro-rated refund would be provided after discharge. Resident #1 expired on / / in the facility. The apartment was vacated of all personal belongings on / . Review of financial documents for Resident #1 show that the discharge date was / . Forty-five days from discharge was .

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

Review of the financial statement printed on for resident #1 revealed that there was a $477.00 overpayment on her account. There was a balance due from Medicaid in the amount of $436.20. The facility stated they were waiting to see if they get paid by Medicaid. At that time, they would either refund the whole amount of $477.00 or, if not paid by Medicaid, they would refund the difference of $40.80. In an interview with the business manager on / at 1:00 PM, she stated that no refund was made and they were waiting for Medicaid to pay the final portion of their bill. She stated that Medicaid had 180 days to pay. After they received the Medicaid payment, they would refund the balance to the resident's daughter. She stated they had not sent a notice regarding the claim against the refund to the family. At 1:30 PM on / , the administrator confirmed that no refund had been made as of the survey date and she was not aware that they only had 45 days to meet their or that they had to notify the family regarding a claim against the refund. The administrator was shown Florida Statute 429.24 regarding the requirement to provide a refund within 45 days of discharge, and that if they intended to make a claim against the refund, they had to notify the resident's family within 14 days of discharge. The administrator stated this notice was not given.
Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

', 2016

Administrator
The Brookshire
85 Bulldog Blvd.
Melbourne, FL 32901

RE: CCR #2016007679

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on ', 2016 by representative(s) 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 29, 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 surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com