STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963865	10/31/2016
NAME OF PROVIDER OR SUPPLIER **BROOKDALE SUNRISE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4201 SPRINGTREE DRIVE** **SUNRISE, FL 33351**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR #2016006867, was conducted on 9/26/2016 and 10/26/16-10/31/16 at Brookdale Sunrise, License #7433. The facility had a deficiency at the time of the investigation.

0025 Resident Care - Supervision

Based on interview and record review, the facility failed to provide care and services to meet the needs of 3 of 3 sampled residents (Resident #1, #2 & #3) who have memory and experienced changes in condition. This was evidenced by the failure to ensure timely direct communication with the health care provider about Resident #1 ' s health condition with multiple and failure to follow facility guidelines for resident transfer for evaluation after . The facility failed to ensure that Resident # 2 and #3, at risk for were reevaluated for an accurate level of supervision and safety requirements for activities of daily living (ADL).

The findings include:

A) In an observation tour of the facility on and residents were observed on a secure memory care unit for and care. Review of the facility ' s employee schedule indicated that the facility had three work shifts: 6 AM - 2 PM, 2 PM- 10 PM and 10 PM- 6 AM. Further review of the employee schedule indicated that the facility employed licensed practical nurses to cover the memory care unit for the morning and evening shifts only. In an interview with the Memory Care Coordinator (MMC) on at 10:00 AM, she stated that licensed nursing staff are available from 6 AM until 10 PM, and only unlicensed caregivers work on the night shift from 10PM- 6 AM. She stated that the staff working at night are not allowed to conduct resident assessments because they are unlicensed. She stated the facility policy required unlicensed staff to call 911 immediately for a witnessed or unwitnessed resident .

Review of Resident #1 ' s medical record indicated that the resident was admitted to the facility on / with medical diagnoses including , and s/p hip repair. Review of the resident ' s health assessment form dated on indicated the resident was alert to self only and had . She required the use of a wheelchair for mobility, required precautions and was of bowel and . Further review indicated that the resident required assistance with ambulation, bathing, dressing, self -care, toileting and transfers.
Review of an incident report dated on indicated that Resident #1 was found in her the floor at 7:15 AM, attempting to ambulate by herself. The report indicated that the resident was assessed by the nurse to have no apparent injury and the physician was notified at 10:00AM. Review of

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physician order fax sheet dated on 10/19/2015 indicated a request for a urinalysis with culture and sensitivity for potential with strong smelling . An order for was obtained, DS every day for 7 days.

Review of Resident #1 ' s " Personal Service Plan " dated on indicated under the escort and mobility section, three components for the facility management program- environmental awareness, functional status and medical conditions. Further review of the plan indicated under the section titled, personalized intervention and potential interventions for prevention of , there was no documentation noted. Additionally, the plan was not signed or dated by a facility manager or resident representative. Review of the record indicated there was no updated service plan after the resident ' s on .

Review of the progress note dated on indicated Resident #1 sustained injury to the left foot, her great toe nail was off and drainage was noted. care orders for the toe were obtained as well as an order for , 500mg twice a day for 7 days. Further review of the progress notes indicated no further documentation/ notes in the resident ' s record until / . Review of the facility progress note dated on I/ indicated that the day shift nurse was informed during report, that Resident #1 had been found on the floor and that the resident had no apparent or injury. Review of an incident report dated on I/ indicated that Resident #1 was found on the floor in her 3:45AM and was placed back in bed by caregivers. The report indicated that a nurse was notified at 3:45AM, and the physician was notified by fax at 6:30PM.

Review of another incident report dated on I/ indicated that Resident #1 was found at 7:00AM on the floor in her . The report indicated that the nurse was notified at 7:00AM and the physician was notified by fax at 7:35 AM. The report further indicated that the resident sustained a to her right upper arm. Review of the facility progress note dated on I/ at 7:00AM indicated that the nurse was called to Resident#1 ' s the resident was transferred to her bed by four caregivers. The nurse assessed the resident and observed a to the right leg and was noted under her left arm.

Review of the facility Physician Notification Fax form dated I/ and time stamped at 9:48AM, indicated Resident #1 had on at 2:45AM and at 7:00AM, and sustained a to her right leg. The documentation on the Physician Notification Fax form does not match the incident reports completed by the facility staff.

Review of a progress note dated I/ at 5:23 PM indicated the nurse was called to Resident #1 ' s assess the resident, who was observed to have discoloration on her left hand. The note indicated that Resident #1 denied pain, she was able to wiggle her fingers without difficulty, and slight

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was noted. Review of the note further indicated that the nurse would " call the physician in the morning to obtain an x-ray of the hand as preventative measure " and the nurse will monitor the resident.

Review of a progress note dated / at 9:15PM indicated that Resident #1 ' s family member called the facility and spoke with a nurse and requested the resident be transferred to the hospital. Further review of the note indicated that a caregiver had informed the nurse that Resident #1 had foul smelling and possible . The note indicated that the resident was sent out 911 to the hospital for evaluation.

Review of Resident #1 ' s hospital record indicated that the resident was admitted to the emergency / at 10:12 PM with the diagnosis of . The physician assessment indicated that the resident was , had with temperatures of 91-92 F, and decreased breath sounds with rales and rhonchi and she was placed on BiPAP . Laboratory tests results indicated abnormal pCO2 -57, elevated white count ( ) 15, and positive culture and sensitivity for testing results showed with , and a of the left hand 4th . Review of the nurse ' s skin assessment dated on / indicated a on the resident ' s right lower leg and was noted on the right upper chest/arm and left and right lower legs. (See photos). Resident #1 was transferred to the for care. Review of hospital discharge summary dated on / indicated that Resident #1 had the following diagnoses: insufficiency with CO2 retention- not improving, with , with /e- , , acidosis, acute exacerbation of , left hand 4th , and due to and cause. The resident was evaluated by a neurologist who recommended care for worsening mental condition and efforts. Resident #1 was transferred to the hospital inpatient hospice unit and on / / .

Review of the facility's " Management Policy and Procedure " dated indicated " the Executive Director (ED) and Wellness Director (HWD) are responsible to verify that associates have completed the facility " Foundations Management " training course during orientation and annually " . Further review of the policy indicated that " if a occurs: assist the resident and provide first aid or call 911 as indicated and to notify the Health and Wellness Director (HWD)/ nurse designee and Executive Director (ED) along with the resident ' s physician/ healthcare provider for evaluation, care and treatment. " The policy indicated that a post investigation was to be completed and individualized interventions for reduction are to be included in the resident ' s service plan.

In an interview conducted on at 2:30PM with the nurse on duty the morning of /

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when Resident #1 sustained , she stated that she came on duty at 6:00AM, she recalled that she was notified that Resident #1 was found on the floor in her room around 7:00AM. She stated that she went to the memory care unit to assess the resident. She stated that she did not recall Resident #1 ' s exact injury but thought it was a . She stated that the resident did not have any other apparent injuries and she notified the family friend by phone and the physician by fax. She stated that she did not speak directly to the physician. She stated that she had not been informed that the resident had been found on the floor earlier that morning at 3:45 AM. She stated that the facility policy/ procedure required that after an unwitnessed , the resident who lived on the memory care unit, should be sent out to the hospital for evaluation. She stated that in hindsight, she should have sent Resident #1 out to the hospital during the morning on / . She stated that the time indicated on the incident report was incorrect, she was notified on at 6:30AM, not 6:30PM, she made an error when completing the report.

In an interview with the HWD on at 1:37 PM and on at 1:30 PM, she stated that if a resident has a witnessed or unwitnessed , the procedure was for the nurse to assess the resident and provide first aide if needed and to ask the resident if they want to go to the hospital. The HWD stated that a memory care resident who has a should be sent to the hospital for evaluation since the resident may not be able to express the incident circumstances or injury due to memory decline. She stated it is better to be safe, than unsafe. When questioned if she was knowledgeable of the written policy, including the completion of post investigation and updating the service plan with individualized interventions; she stated that she was new to the facility and not yet familiar with all the policies. She stated that since she has been at the facility, she had discussed interventions at staff meetings but had not documented the interventions in the resident medical records. She stated that all caregivers employed at the facility must complete the management training before beginning employment. She stated that the caregivers for Resident #1had not followed the facility policy to send the resident out for evaluation after her /s.

In an interview with Resident #1 ' s physician on / at 5:35 PM, she stated that she recalled that her office had been notified by fax of the resident ' s with on / . The physician stated that she did not recall any further details of the resident ' s on / . She stated that she had spoken with the facility nursing staff and believed that the nursing staff were monitoring the resident after her and conducted checks every few hours. She stated that she recalled that she was notified during the evening on / that Resident #1 had been transferred to the hospital for evaluation of a painful, hand and symptoms of a potential .

B) Review of Resident #2 ' s medical record indicated the resident was admitted on / with medical diagnosis of advanced ' s with . Review of the current resident health assessment form, 1823 dated on indicated that the resident was independent for ambulation and transfers and required assistance with bathing, dressing, self -care and toileting. The

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form indicated the resident was alert and oriented to self, with and required precautions.

In an observation of Resident #2 on at 10:30AM , she was observed sitting at a table in the activity room. The resident was alert to name only; she was unable to answer simple questions.

Review of Resident #2 ' s progress notes dated on / indicated the resident was found on the floor at 4:30 PM, and expressed no complaints of pain. The note indicated that the physician was notified by fax of the and the resident was not transported to the hospital for evaluation.

Review of Resident #2 ' s progress note dated on indicated the resident was found at 8:00AM on the floor, she was unable to express what had happened and she denied having pain. The physician was notified by fax and the resident was not transferred to the hospital for evaluation.

Review of Resident #2 ' s progress note dated on indicated at 3:00PM, the resident was observed by staff to to the floor after another resident pulled at her clothing. The resident denied pain, and the physician was notified by fax. The resident was not transferred to the hospital for evaluation.

Review of Resident #2 ' s current service plan dated on / indicated interventions under management to include: be alert to heightened risk for falling, encourage resident in program participation as means of increase observation, check with physician for changes and review labs and medications.

In an interview with the Memory Care Coordinator on at 10:45AM, she stated that Resident #2 was a risk, due to her history of . She stated that the resident required staff supervision with ambulation. The coordinator stated that the resident had memory loss and would not be able to alert staff if she was sustained injury after a .

In an interview with the HWD on at 1:00PM, she stated that she was not aware that the resident assessment form 1823 for Resident #2 was not accurate. She stated that the resident was not independent with ambulation since the resident had a history of and required precaution. She stated that the resident should be supervised by staff with ambulation and transfers.

C) Review of Resident #3 ' s medical record indicated that the resident was admitted to the facility with medical diagnoses including , , lower extremities, hearing loss and .
Review of the current resident health assessment form dated on / / indicated that the resident was independent for ambulation, eating, self-care, toileting and needed assistance with bathing and dressing. The form indicated the resident required no other precautions. Review of the resident ' s

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individualized service plan dated on 3/2/2015 indicated the use of a walker and required cueing for mobility to and from meals, activities, and common areas.

Review of an incident report dated on / indicated Resident #3 was found on the floor of the public the memory care dining 12:00PM. The report indicated the resident had no apparent injury and the physician was notified. The resident representative was notified and refused to have the resident transported to the hospital.

Review of Resident #3 ' s personal service plan dated on indicated that the resident ' s memory required escort assistance on the unit and precautions. The plan indicated that Resident #3 had in the last 12 months, had with injury requiring hospital treatment, and required the use of a walker as a mobility aid. Interventions included, request further evaluation with physician, review labs and medications and encourage program participation as a means for increased observation. Further view of the resident record indicated that the resident assessment form 1823 had not been updated to reflect the resident ' s current activities of daily living status and requirements.

Review of Resident #3 ' s progress noted dated on / at 7:15PM indicated the resident was ambulating in the memory care unit hallway, when she complained of and was assisted to the floor. When the nurse observed the resident, she was lying on the floor and had no apparent injury. A phone message was left for the physician and the resident remained in the community. Review of the progress notes for - indicated no communication with the resident ' s physician.

Review of an incident report dated on / at 6:00PM indicated that Resident #3 was observed in the memory care dining to move a chair, when she backwards, sitting on her bottom and sustaining a to her left elbow. The report indicated the nurse provided first aid and the physician was notified by fax.

Review of an incident report dated on at 8:15PM indicated that Resident #3 was found on the floor in the hallway, with no apparent injury. The physician was notified by fax; no phone call was placed by the nurse to notify the physician of a 2nd within the 24-hour period. Review of the facility progress notes from / and indicated no communication with the resident ' s physician.

Review of an incident report dated on / at 3:00PM indicated that Resident #3 stood up from her chair, lost her balance and backwards, hitting the back of her head. The nurse found the resident on the floor and first aid was applying to back of resident ' s head. The report indicated that the resident was transported to the hospital via 911 for evaluation.

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Review of Resident #3 ' s hospital discharge note dated on 10/21/2016 at 6:19PM indicated a diagnosis of head injury. Review of the resident ' s discharge instructions included to monitor the resident for 24 hours and awaken the resident every 2 hours to determine responsiveness and observe for signs and symptoms of worsening condition as listed on the instruction sheet.

Review of Resident #3 ' s progress note dated / at 9:00PM indicated the resident returned to the facility after evaluation at the hospital. The note indicated that a head and spinal performed and showed no injury and no new physician orders were received. The note further indicated the resident denied having any pain.

Review of Resident #3 ' s progress note dated on at 8:15AM indicated that the nurse documented that the resident was observed to have no pain or discomfort and was noted to the resident ' s head. Further review of the progress notes indicated there was no documentation that the resident was observed every 2 hours as per the hospital discharge instructions.

In an interview with the Licensed Practical Nurse (LPN) on at 10:45 AM, she stated that she had observed the resident on and had written the progress note. She stated that there are no nurses on duty during the night shift and she was unaware if the unlicensed staff had awakened the resident during the overnight on / - to make any observations. She stated that the head was negative, therefore monitoring or checks would not be necessary. She stated that Resident #3 had not complained of any discomfort or shown any symptoms since the .

In an interview with the HWD on at 1:00PM, she stated that Resident #3 had a history and precautions should be followed. She stated that the nursing staff should have contacted the physician directly after the resident had multiple in a day. She stated that she would be recommending that Resident #3 be reevaluated by her physician and her medications reviewed. She stated that upon readmission, after her head injury, Resident #3 should have been observed by the care staff as recommended and documentation completed. She stated that she was always available by phone for consultation to the facility care staff. She stated that the resident service plan should be reviewed and updated with personalized interventions to reduce risk.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2016

Administrator
Brookdale Sunrise
4201 Springtree Drive
Sunrise, FL 33351

RE: CCR #2016006867

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on [redacted], 2016 and [redacted], 2016 through [redacted], 2016 by a 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 [redacted]-Davis
Field Office Manager

AMD
Enclosure

XG90

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