STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	**04/26/2017**
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 Relicensure survey with Extended Congregate Care (ECC) and Limited Nursing Services (LNS) was conducted on . . . . The Brookshire, License #7354, had deficiencies found at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interview, observations and record review,the facility failed to ensure 1 of 3 sampled residents was treated with consideration and respect and with due recognition of personal dignity (#3).

Findings:

In an interview on at 10:45 AM,resident #3 stated meat served was dry, the menu was repetitious with the same food all the time, and chicken was served very frequently.

Observations on . . . at 12:15 PM noted resident #3 sat in the dining . He was eating a cheeseburger. There was a plate next to him with a pasta and cheese dish. The resident who sat across him had the pasta and cheese dish. Resident #3 stated that he knew he told the Agency representative earlier about eating chicken too often but when he heard there was fried chicken for lunch he was excited. Once he came to the dining . . . , he was told by the dietary staff that there was no more chicken because they did not make enough. He settled for eggplant lasagna, which was burnt. He said the pasta plate next to him was what he was served and he did not eat it because it was burnt, and asked why they would serve him that. He turned the noodles on the plate over. They were black and dried, so he was offered a cheese burger, which he ate but he really wanted fried chicken.

In an interview on . . . at 4:30 PM, the dietary manager said "The resident wanted fried chicken. I offered eggplant lasagna, which had a little burnt cheese. He asked for a hamburger. I ordered one case of chicken which was not enough for all."

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, interview and record review, the facility failed to make every reasonable effort to ensure medications were filled and refilled in a timely manner for 2 of 4 sampled residents who received assistance with self-administration of medications (#1 & 2).

Findings:

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1. On at 10:11 AM, resident #1 said the facility ran out of her , a few months ago and it was never reordered. She believed she was supposed to still take it. She spoke with her Advanced Registered Nurse Practitioner (ARNP) who told her the medication had not been discontinued.

Review of her Medication Observation Records (MOR) for , 2017 and , 2017 revealed an entry for , 75 milligrams (mg.) capsule, take 1 capsule by mouth twice daily for chronic pain, scheduled to be given at 9 AM and 5 PM. The medication was signed as given from through .

Review of resident #1's MOR for 2017 and , 2017 revealed documentation that indicated the , was unavailable from through .

An undated notation on the 2017 MOR indicated the medication was discontinued, and a notation on the , 2017 MOR indicated the medication was discontinued on .

Review of resident #1's record did not reveal any documented evidence to indicate a health care provider discontinued the medication.

Resident #1 was readmitted to the facility on following a stay in a rehabilitation facility. A health assessment form (1823), dated , indicated she required assistance with her medications.

A transfer/discharge report from the rehabilitation facility, dated , contained a list of medications for resident #1 that included , 75 mg. two times a day for chronic pain.

Resident #1's record contained physician order forms dated , , , and that listed , 75 mg. twice daily. Each form was signed by an ARNP.

Encounter forms documented by an ARNP and dated , , and , indicated resident #1 had spasms of her back muscles, low back pain, , , , hip pain, and neck pain. The forms indicated her medications were reviewed and the list included , 75 mg. twice a day.

On at 3:15 PM, the director of nursing confirmed , was unavailable, confirmed resident #1 did not receive the medication, and said she believed the medication was discontinued while resident #1 was in the rehabilitation facility. She confirmed there was no documented evidence to indicate a health care provider had discontinued the medication.

Observations made of the medication containers for resident #1 on at 3:40 PM did not reveal

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any available.

On at 3:45 PM, resident #1 said as a result of not receiving the , she experienced sharp pain and cramping in her legs, and felt at times like her feet would off. She described the level of pain as an 8 out of 10, with 10 being the worst.

2. On at 11:30 AM, resident #2 said there were days she did not have her medication.

Record review for Resident #2 revealed an 1823 form, dated , with diagnoses that included , and .

Resident #2's record revealed an order for Z-Pak as directed on /1. Review of the MOR revealed the medication was not given until . The back of the MOR noted on at 9 AM the medication was not available and at 1 PM the back of the MOR noted "Z pak came in given."

Resident #2's record revealed the following order from the health care provider on . "The resident was diagnosed with as of today and is to start Z 0.004%, 1 drop nightly in both eyes." " Z® (, solution) 0.004% is a once-a-day eye drop you take in the evening to help reduce the elevated pressure inside your eye." (.com). Review of the and MORs revealed the eye-drops were not available until .

Review of the , and MORs revealed medication were not refilled timely and were not available as follows:

, ( ) 0.5 milligrams (mg.) take one three times daily at 9 AM, 1 PM and 5 PM. " is a benzodiazepine used to treat or associated with . Learn about side effects, interactions and indications." (drugs.com).
The back of the MOR noted on
- - was not available at 9 AM and 1 PM
- - was not available at 1 PM
- - was not available at 5 PM
- - was not available at 9 AM and 1 PM
- - was not available at 9 AM
- - was not available at 9 AM
- - was not available no time noted
- - was not available at 5 PM

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- was not available at 9 AM
- was not available at 1 PM

Every day at 9 AM, 1 PM and 5 PM from through there were staff initials with circles that indicated the medication was not given.

ProAir Inhale, 2 puffs four times daily at 9 AM, 1 PM, 5 PM and 9 PM. "ProAir® HFA ( ) Inhalation Aerosol is indicated....for the treatment or prevention of , with reversible airway and for the prevention of exercise- ." (proair.com).
The back of the MOR noted on
- ProAir at 9 AM, 1 PM, was not available
- ProAir at 9 AM, 1 PM was not available
- ProAir at 9 AM, 1 PM was not available
- ProAir at 9 AM, 1 PM was not available

Every day at 9 AM, 1 PM, 5 PM and 9 PM from through there were staff initials with circles that indicated the medication was not given.

25-200 mg. one twice daily at 9 AM and 5 PM. " is used to reduce the risk of in people who have had clots or a 'mini- ' (also called a or)." (drugs.com). The back of the MOR noted on
- was not available at 5 PM
- was not available at 9 AM
- was not available at 9 AM
- was not available at 9 AM

Every day at 9 AM from through there were staff initials with circles that indicated the medication was not given. The 5 PM dosages were marked as given

25 mg. one three times daily as needed for . " is used to treat or prevent , and caused by motion sickness." (drugs.com).
The back of the MOR noted on
- 25 mg. at 9 AM not available
- 25 mg. at 9 AM not available.

On at 2 PM, the Director of Clinical Services said when the health care provider ordered the Z-pak, they were waiting for the pharmacy to deliver. She said there was a problem with the insurance company getting the eye drops for . She reviewed the MOR and confirmed there were days the resident did not get her medication because the staff noted it was unavailable.

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Class II

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on observation, record review and interview, the facility failed to ensure its dietary manager had annually obtained a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility (ALF).

Findings:

On at 11 AM, a tour of the facility kitchen was conducted with the staff E and the executive director (ED). The ED confirmed that staff E was in charge of food services at the facility. When staff E was asked to provide a certification of an annual 2-hour nutritional and food services in ALF, she stated she did not have one. The only certification regarding nutritional training she had was dated 2014.

On at 11 AM, the ED confirmed staff E did not have the annual 2-hour training.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, record review and interview, the facility failed to have the original signature of the licensed dietitian who reviewed and approved its 4-week menus, failed to accurately use the correct menu for the week, failed to provide a therapeutic diet as ordered by a health care provider for 1 of 4 sampled residents (#1), and failed to ensure 1 of 4 residents' nutritional needs were met (#3).

Findings:

1. A review of the facility 4-week menus revealed they were not dated and signed by a licensed or registered dietitian. At 12:45 PM, the dietary manager provided a "Menu Review and Approval", dated , , 2017. It read, "Cycle 1 menu, regular and therapeutic diet plans, has been reviewed, approved, and accepted for use....for the period of... , 2017 to 2017." The form had an electronic signature of the reviewer. The dietary manager stated she printed this letter from her e-mail message. She stated she did not have the original signature of the licensed dietitian who reviewed and approved the menus for the facility.

2. On at 11 AM, the dietary manager stated she followed Week 2 menus for today. When asked how she decided it was week 2, she provided a menu schedule for 2017. According to the schedule, the week of - was listed under "Week One" menus. The dietary manager

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confirmed that she used the wrong week menus.

3. On at 10:11 AM, resident #1 said she had difficulty chewing meat.

Review of her record revealed she returned to the facility on following a stay in a rehabilitation facility. A health assessment form 1823, dated , indicated her diet was mechanical soft with puree meat.

A speech , progress note from the rehabilitation facility, dated , indicated she had and her diet was downgraded to mechanical soft with pureed meats. "Difficulty swallowing ( ) means it takes more time and effort to move food or liquid from your mouth to your stomach." (mayoclinic.org).

Observations made during the lunch meal on revealed resident #1 was served fried chicken that was not pureed. She did not eat the chicken and said it was because she was unable to chew it.

On at 2:45 PM, resident #1 said the facility had not served her puree meat since she returned from the rehabilitation facility on .

On at 3:12 PM, the facility dietary manager said she was unaware resident #1 had an order to receive pureed meat.

On at 3:45 PM, resident #1 said she coughed sometimes when she ate.

4. On at 10:45 AM, resident #3 stated that meat served was dry, chicken is served a lot, and the same food was served all the time. The resident said, "They run out of food, run out of eggs. Now we get eggs."

Observations on at 12:15 PM noted resident #3 sat in the dinning . He was observed eating a cheeseburger. There was a plate next to him with pasta and cheese dish. The resident who sat across him had the pasta and cheese dish. Resident #3 stated he knew he told the Agency representative earlier about eating chicken too often but when he heard there was fried chicken for lunch, he was excited. Once he came to the dining , he was told by the dietary staff that there was no more chicken, they ran out because they did not make enough. So he settled for eggplant lasagna, which was burnt. He said the pasta plate next to him was what he was served and he did not eat it because it was burnt and asked why would they served him that. He turned the noodles on the plate over and they were black and dried. He was offered a cheese burger, which he ate but he really wanted

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fried chicken.

On at 4:30 PM, the dietary manager said the resident wanted fried chicken, but she only ordered 1 case of the fried chicken and evidently that was not enough. She offered the resident eggplant lasagna which had a little cheese. He asked for a hamburger instead. She said normally when she made chicken, she also made a pasta dish which the residents liked and there was enough for all. Regarding how much food to order to feed 115 residents, she said she did not have a formula for how much food to order.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to have record of semi-annual weights for 2 of 3 sampled residents who required assistance with activities of daily living (#2 & 3).

Findings:

1. Resident #2's health assessment form (1823), dated , noted she required assistance with ambulation, bathing, dressing and transfers. The record did not reveal any weight record available for review for 2016. The only weights recorded was for 2017.

2. Resident #3's 1823, dated , indicated he needed assistance with ambulation. The record did not reveal any evidence to confirm that his weights were taken in 2016. The weight records available for review were dated and .

On at 1 PM, the Director of Clinical Services said she could not locate the 2016 weight records, that a staff used to maintain the records but was no longer employed at the facility , and she did not know where they were.

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and interview, the facility failed to ensure that 1 of 2 sampled residents contracts contained all the required components (#2).

Findings:

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Resident #2's record revealed the contracts did not contain a provision that indicated the residents must be assessed upon admission pursuant to subsection 58 A-5.0181(2), Florida Administrative Code and every 3 years thereafter, or after a significant change.

On at 4 PM, the administrator confirmed the finding.

Class

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on resident record review and interview, the facility did not ensure nursing services were conducted and supervised in accordance with Chapter 464, Florida Statutes, and the prevailing standard of practice in the nursing community, for 1 of 3 sampled residents who received Limited Nursing Services (LNS), and allowed Licensed Practical Nurses (LPNs) to conduct nursing assessments (#3).

Findings:

During the facility entrance interview on at 9:30 AM, resident #3 was identified as receiving LNS for the application and removal of compression stockings.

Resident #3's record revealed she received LNS for the application and removal of compression stockings. A healthcare provider's order, dated , indicated compression stockings were to be on in AM and off at bedtime.
The nursing assessments, dated , , , , and were all conducted and signed by an LPN and co-signed by RN.

There were 2 assessments signed by the LPN but not completely dated. The month and year was indicated but not the day: 4/_ /17 and 10/_ /16.

In an interview on at 4 PM, the administrator and RN said that since the LPN was the director of nursing.

Class III