

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 08/31/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932514	(X3) DATE SURVEY COMPLETED 08/10/2017
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 complaint investigation (2017005948) was conducted on [redacted], 2017. The Brookshire, license #7354, had deficiencies at the time of the investigation.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record reviews and interview the facility failed to ensure that as part of the continued residency criteria, 1 of 3 sampled residents (#3) had a new health assessment form 1823 completed every 3 years.

Findings:

Record review for resident #3 revealed that her most recent health assessment form 1823 was dated on [redacted]. Her record did not contain evidence to indicate that a new 1823 was completed every 3 years, as required.

During an interview with the director of nursing on [redacted] at 4:15 pm, she confirmed the finding.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record reviews and interviews the facility failed to notify a health care provider when 1 of 3 sampled residents (#1) had a change in condition.

Findings:

Record review for resident #1 revealed a health assessment form 1823 that was dated on [redacted]. The form indicated that he had diagnoses of [redacted] () with right [redacted], Aphasia, right shoulder pain, right arm and leg [redacted], complete foot [redacted], and [redacted].

A nurse's note that was dated on [redacted] at 10:30 am indicated that the Director of Nursing (DON) went to his [redacted] see why he sent his [redacted] to the dining [redacted] his food, why he called his mother to say he was so very sick, why he was not getting out of bed, and why he said no one was helping him. When the DON asked him if he wanted to go to the hospital, he replied no.

A nurse's note that was dated on [redacted] at 11:45 am indicated that his mother called the facility and said that resident #1 did not feel well and that no one had checked on him. The nurse instructed his mother to call his doctor and provide the doctor with the number of the facility so the staff could speak

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with the doctor. The nurse went to the resident #1 and observed an empty bottle of Jack Daniels and two glasses with yellow fluid. The DON and administrator went into the asked resident #1 if he wanted to go to the emergency he replied no. The nurse would continue to monitor him. During an interview with the administrator on at 12:45 pm regarding additional details of the nurse's notes, she said when resident #1 did not get his or money to buy , he became sick. She said she never spoke with resident #1 about that but she believed it to be true because she could smell on his breath and he spoke loudly when he drank. She said resident #1 would throw beer cans on the floor of his he would tell housekeeping to pick them up. She said she did not document those events. She said that on resident #1 in glasses because he said he was unable to get up, even though he was able to sit up on the side of the bed and he had a wheel chair in his . A change in condition note was completed by the DON and dated on indicated that resident #1 appeared to be inebriated, his symptoms had gotten worse, and he was . He called for assistance from the staff to empty his glasses. When questioned why he was not getting out of bed to use the , he replied that his was acting up. When asked if he needed to go see his doctor, he replied that he already saw the doctor and he was prescribed a new medication. The DON told him that would irritate his condition more. He replied that he was trying not to but the DON observed several empty beer cans on his window ledge. During an interview with the DON on at 1:43 pm regarding the details of her note, she said she did not call the health care provider for resident #1 on when he appeared to be inebriated and . She said resident #1 "had always been a drinker, since he got here." She said she had not discussed the resident's use of in combination with his prescribed medications with his health care provider. During an interview with the DON on at 3:09 pm regarding additional details for the note that she wrote on , she said resident #1 told her that he was unable to get out of the bed because of his . She said she did not contact his health care provider. Class III		