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	AL11964787	08/23/2017
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0000 - Initial Comments

An unannounced Re-Licensure with Limited Nursing Services (LNS) survey was conducted on 22-23, 2017 at Brookdale Jensen Beach (License #9294). There were deficiencies identified at the time of the survey.

The LNS portion of this survey was conducted on a separate date. Please refer to the LNS survey report for the findings.

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

Based on observations, interviews and record reviews, the facility failed to:
1. Ensure a resident was appropriate for continued residency at the facility;
2. Ensure the required Interdisciplinary Care Plan ( ) was developed and maintained for a resident receiving in-home hospice services; and,
3. Obtain an updated AHCA Form 1823 (medical examination) when a resident experienced a significant change in condition.
This affected 1 of 1 residents reviewed for hospice services (Resident #5).

The findings included:

Resident #5 was observed on at 10:00 AM in his bed sleeping. On at 9:20 AM, he was observed in his bed, awake, alert, friendly and . No signs of distress or discomfort were observed. A full resident interview was conducted at that time.

On at about 2:45 PM with another surveyor present, Resident #5's hospice Care Manager was interviewed by telephone and provided the following information:
1. He was admitted to hospice services on .
2. On , a Registered Nurse (RN) visit report documented observation of a , on his right fold ( ).
3. On , a RN visit report documented observation of a , on his right fold, and a second , on his (tail bone).
4. On , a RN visit report documented observation of multiple wounds to his right ; a was observed on his right fold. care treatments were increased to "daily".
5. On , a RN visit report documented observation of a , to this right fold, and a , to his .

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Review of Resident #5's hospice and facility records revealed the following documents:

1. Two facility Open Area Flow Sheets dated and signed by a facility nurse. One was for a on his right (middle). The other was for a on his right , (top). Both forms had the same data, and the Date Open Area Identified was listed as .

2. His Personal Service Plan dated , in the section titled Skin Care, documented:
"Resident has a (s).
--> Refer to the Nutrition at Risk program related to open areas.
--> Refer to the Open Area Flow Sheet.
care for one , is provided by Home Health.
Note: [Facility] policy and/or state regulations may require specific monitoring of wounds."

3. Notes from the home health agency nurse included:

a. A note documented, "Wounds on R cleanse [with] NS , dry Gell appl. sec [with] DSD Patient tolerated well. Good healing progress"

b. A note documented, "No care order change since last visit. meas [R] wrist healed Lt meas 0.5 x 0.5 x 0.01; mid 0.5 x 0.3 x 0.1; lower 2.5cm x 2.5cm x 0.2 cm"

c. A note documented, "... discharge - d/c to hospice"

3. Notes from hospice staff included:

a. The nursing visit record, section titled Evaluation of Process, included, " ... noted in left [should be right] fold area ..."

b. The Nursing Visit Record LPN documented:
i. to right fold with "soft gray eschar covering the ", and small drainage amount, brown drainage color, foul odor
ii. to with, "Identify stage: , eschar, yellow , small amount of lower periphery of the "

c. A Assessment & Intervention Record documented:
i. to right fold, length 5 centimeters (CM), width 5 CM, depth 3.5 CM, large drainage

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amount
ii. to , length 3 CM, width 3 CM, depth 2.5 CM, yellow

d. An "As of Forms" document contained:
i. to right fold with "a small strip of yellow remains attached to the bed. observed in the center of the .", and large drainage amount, color
ii. to with, "Identify stage: Unstageable, eschar ... soft gray eschar remains attached to half of the 's surface.", and large drainage amount, foul odor

e. A Nursing Visit Record documented:
i. to right fold, length 4.5 CM, width 2.7 CM, , medium drainage amount
ii. to , length 3 CM, width 3 CM, depth 1.8 CM, large drainage amount

f. A Nursing Visit Record LPN documented:
i. to right fold with "exposed, large drainage amount, color"
ii. to with "yellow , very small amounts of remain, large drainage amount, brown color, foul odor"

g. A Assessment & Intervention Record documented:
i. " " and "Location right fold [ ] exposed with large drainage amount and drainage color" ... "A cavity has formed in the center of the ."
ii. "Open Location 2" ... " " [tail bone] exposed with large drainage amount and and brown color"

On at 3:15 PM, the Health and Wellness Director (HWD), a Licensed Practical Nurse (LPN), was asked and stated they received no more recent documentation from hospice staff at this time.

On at 3:45 PM, the HWD was asked and stated the facility had issued a 45-day notice of discharge related to the non-healing , about 60 days before but did not enforce it; a copy of the notice was requested. At 3:51 PM, the HWD, with the facility's Administrator present, was asked again about the 45-day notice. The Administrator stated she thought it was in her office. At 4:10 PM, the HWD stated there was no copy of the 45-day notice of discharge available for review.

A telephone interview was conducted on at 3:40 PM with Resident #5's family member and Power of Attorney. She was asked and provided the following information. She sees the resident 3 or 4 times a week. She was aware of his , issues and related treatment. She was told by facility staff that the non-healing status of the wounds was related to the process. She

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further stated she was never told about, nor received, a written 45-day notice of discharge.

Based on observations, interviews and record reviews, the facility failed to:
1. Ensure a resident was appropriate for continued residency at the facility;
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3. Obtain an updated AHCA Form 1823 (medical examination) when a resident experienced a significant change in condition.
This affected 1 of 1 residents reviewed for hospice services (Resident #5).

The findings included:

Resident #5 was observed on at 10:00 AM in his bed sleeping. On at 9:20 AM, he was observed in his bed, awake, alert, friendly and . No signs of distress or discomfort were observed. A full resident interview was conducted at that time.

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5. On , a RN visit report documented observation of a , to this right fold, and a , to his , .

Review of Resident #5's hospice and facility records revealed the following documents:

1. Two facility Open Area Flow Sheets dated and signed by a facility nurse. One was for a on his right (middle). The other was for a on his right , (top). Both forms had the same data, and the Date Open Area Identified was listed as .

2. His Personal Service Plan dated , in the section titled Skin Care, documented: "Resident has a (s).

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--> Refer to the Nutrition at Risk program related to open areas.
--> Refer to the Open Area Flow Sheet.
care for one , is provided by Home Health.
Note: [Facility] policy and/or state regulations may require specific monitoring of wounds."

3. Notes from the home health agency nurse included:

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c. A Assessment & Intervention Record documented:
i. to right fold, length 5 centimeters (CM), width 5 CM, depth 3.5 CM, large drainage amount
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d. An "As of Forms" document contained:
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e. A Nursing Visit Record documented:
i. to right fold, length 4.5 CM, width 2.7 CM, , medium drainage amount
ii. to , length 3 CM, width 3 CM, depth 1.8 CM, large drainage amount

f. A Nursing Visit Record LPN documented:
i. to right fold with "exposed, large drainage amount, color"
ii. to with "yellow , very small amounts of remain, large drainage amount, brown color, foul odor"

g. A Assessment & Intervention Record documented:
i. " " and "Location right fold [ ] exposed with large drainage amount and drainage color" ... "A cavity has formed in the center of the ."
ii. "Open Location 2" ... " " [tail bone] exposed with large drainage amount and and brown color".

4. The resident's last health assessment (AHCA Form 1823) was completed on . There was no subsequent assessment completed when the resident encountered a significant change. The resident had a significant change in status when he developed a pressure on . Another significant change occurred when the resident was admitted to hospice on .

On at 3:15 PM, the Health and Wellness Director (HWD), a Licensed Practical Nurse (LPN), was asked and stated they received no more recent documentation from hospice staff at this time.

On at 3:45 PM, the HWD was asked and stated the facility had issued a 45-day notice of discharge related to the non-healing , about 60 days before but did not enforce it; a copy of the notice was requested. At 3:51 PM, the HWD, with the facility's Administrator present, was asked again about the 45-day notice. The Administrator stated she thought it was in her office. At 4:10 PM, the HWD stated there was no copy of the 45-day notice of discharge available for review.

A telephone interview was conducted on at 3:40 PM with Resident #5's family member and Power of Attorney. She was asked and provided the following information. She sees the resident 3 or 4 times a week. She was aware of his , issues and related treatment. She was told by facility staff that the non-healing status of the wounds was related to the process. She further stated she was never told about, nor received, a written 45-day notice of discharge.

Based on these findings, the resident was no longer appropriate for continued residency in an ALF

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(Assisted Living Facility) due to a pressure first identified on . Additionally, there was no interdisciplinary care plan, which specifies the services provided by hospice and the facility, to ensure the resident received all interventions to prevent the worsening of the pressure . The facility provided no additional documentation for review at this time.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review and interviews, the facility failed to ensure the Medication Observation Record (MOR) had accurate medication schedule times for 4 out of 5 sampled residents (Residents #16, #17, #18 and #19).

The findings included:

On , Staff E (unlicensed aide) was observed assisting the following residents with self-administration of their morning medications. The 2017 MORs listed the scheduled time for these residents to receive their medication as 9:00 AM.

1. Resident #16-10:20 AM (scheduled on MOR for 9:00 AM)

a.
b.
c. HCl
d.
e.
f.
g.
h. D
i.
j.

2. Resident #17-10:30 AM (scheduled on MOR for 9:00 AM)

a. nasal
b.
c.
d.

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e. L-Methylfolate
f.
g.
h. D3
i.
j.

3. Resident #18-10:35 AM (scheduled on MOR for 9:00 AM)

a.
b.
c.
d. ER
e. MVI
f.
g. Ensure

4. Resident #19-10:50 AM (scheduled on MOR for 9:00 AM)

a.
b.
c.
d. HCl
e. ER
f. Perles

The Health and Wellness Director and Administrator were notified of the above findings during interview on at 4:00 PM. They acknowledged that the medication distribution times were not within a 2 hour window (1 hour before, 1 hour after) of the times listed on the MORs for these residents, and that the scheduled times could be adjusted. The facility provided no additional documentation for review at this time.

Class III

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

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who assist residents with self-administration of medications followed appropriate standards of practice for 2

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of 9 sampled Residents (#1 and #3) by not following Health Care Provider (HCP) orders as written, and not seeking clarification for an order that required unlicensed staff to assess a resident and use their own discretion regarding the appropriate dose to be given.

The findings included:

1. On around 9:31 AM, Staff C, a Home Health Aide and Medication Technician (MT), was observed applying a medication patch to Resident #3's upper left side of her chest. Review of her medications and related records revealed the following:

a. A written HCP order calling for " Patch 24 Hour 0.2 MG/HR Apply 1 patch in the morning to prevent chest pain".

b. Observation of the label on the medication container, and her review of her 2017 medication observation record (MOR), revealed an entry dated calling for, " patch 24 Hour 0.2 MG/HR Apply 1 patch in the morning for prevent chest pain ON in AM of in PM HOLD patch if B/P is less the OR rate below 58".

c. The MOR also had an entry dated calling for, "Please place ALL patches on middle of back between should blades so resident cannot reach and remove per MD. one time a day for medication administration".

d. The Location of Administration (where the patch was applied) column on her 2017 "Location of Administration Report" documented all but 1 patch was applied to either her "Chest - left" or "Chest - right". On , the location of administration was recorded as "Ankle - outer (right)".

An interview was conducted on at 9:40 AM with Staff B and C, both staff members are MT's. Both stated Resident #3 has a behavior of picking at and pulling off her patches.

This was discussed and acknowledged by the Health and Wellness Director (HWD), a Licensed Practical Nurse (LPN), on at 9:55 AM.

2. Review of Resident #1's medications and medication record conducted revealed the following:

a. A written HCP order calling for, " ( ) [an anti- medication] 0.25 MG tablet Take one-half to one tablet by mouth three times daily as needed for ".

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b. Observation of the label on the medication container, and review of her ... 2017 MOR revealed an entry dated calling for, " , tablet 0.25 MG by mouth as needed for , Take 1/2 to 1 tab po prn for ".

This practice called for unlicensed staff to use their own discretion regarding the appropriate dose to be given, a half pill or a full pill. Further record review revealed no documentation showing staff obtained clarification from the HCP regarding this order.

These concerns were discussed with and acknowledged by the HWD on at 1:38 PM.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and a staff interview, the facility failed to ensure 1 out of 3 sampled employees (Staff B) had submitted a written statement annually from a health care provider documenting freedom from ( ).

The findings included:

During personnel record review for Staff B, date of hire , a signed statement by a health care provider, dated within the previous year, verifying this employee was free from could not be found.

A request was made to the Business Office Manager and Health and Wellness Director (HWD) for the documentation on at 3:00 PM, but they were unable to locate this documentation at the time of the survey. The facility provided no addtional documentation of the required statement for review at this time.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and an interview, the facility failed to ensure that 2 out of 2 sampled unlicensed staff members (Staff B and C) who provided assistance with self-administered medications had successfully completed a minimum 2 hours of annual continuing education training on providing assistance with self-administered medications and safe medication practices in an ALF.

The findings included:

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a) The personnel file for Staff B (hired) was reviewed for documentation of a minimum of 2 hours of continuing education training annually on providing assistance with self-administered medications and safe medication practices in an ALF. There was no documentation of this training dated within the previous year for this unlicensed resident aide who provided assistance with self-administration of medication to residents.

b) The personnel file for Staff C (hired) was reviewed for documentation of a minimum of 2 hours of continuing education training annually on providing assistance with self-administered medications and safe medication practices in an ALF. There was no documentation of this training dated within the previous year for this unlicensed resident aide who provided assistance with self-administration of medication to residents.

The Business Office Manager and Health and Wellness Director (HWD) were interviewed at 1:30 PM on and confirmed that the documentation was not present and available for review. The HWD identified both Staff B and C as staff who provided medication to residents. The facility provided no additional documentation for review at the time of the survey.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and interviews, the facility failed to ensure certificates of completed training with all required components were on file for 4 out of 4 sampled staff (Staff A, B, C and F).

The findings included:

On at 1:00 PM, the personnel files for Staff A, B and C were reviewed with the Business Office Manager. She stated that the employees complete orientation that includes training in all required in-services within 30 days of hire. However, the following certificates of training could not be located:

1. Staff A-Date of Hire

a) Facility's Emergency Procedures (part of 1 hour)
b) Safe Food Handling (1 hour)
c) Facility's Elopement Policy and Procedure (no time required)
d) Facility's Policy and Procedure (1 hour)

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2. Staff B-Date of Hire

a) Incident Reporting (part of 1 hour)
b) Activities of Daily Living (ADLs) (3 hours)

3. Staff C-Date of Hire

a) Incident Reporting (part of 1 hour)
b) Safe Food Handling (1 hour total)
4. Review of the Director of Dining Services' (DDS)/Staff F's personnel records revealed the following:

a. A certificate for "Servsafe Food Protection Manager".

b. A certificate for "Crandall Corporate Dietitians Florida Regulatory Compliance 2-Hour Course". This was provided by a Registered Dietitian and contained information substantially similar to the "Food Service and Nutrition in an ALF" required training for ALF (Assisted Living Facility) food service managers.

c. In an interview conducted at 2:00 PM, the DDS was asked and stated he has worked at this facility for about 9 months; this was his first job in a health care setting. He had not completed an approved ALF CORE training course, nor had he completed the food and nutrition services module of the CORE training course before assuming responsibility for the facility's food service.

These findings were discussed and acknowledged by the Health and Wellness Director, with the Administrator present, on at 3:15 PM.

Class III

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

Based on observation, record review and interviews, the facility failed to ensure 1 out of 1 sampled residents (Resident #10), who received a pureed diet, had meal items served with substitutions of equal nutritional value.

The findings included:

a) On at 12:30 PM, staff in the secured unit were observed serving lunch delivered by the kitchen to the residents. The dietician approved menu dated indicated that the residents were to

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be served the following items:

1. Navy bean soup
2. Herb encrusted cod/Cottage cheese and fruit plate/Spaghetti with meat sauce
3. Tater tots
4. Steamed carrots
5. Roasted Cauliflower
6. Brownies

At the conclusion of the meal service, the Resident #10 had not been served any soup or dessert. Only 2 of the meal items were identified on the resident's plate: spaghetti with meat sauce and cauliflower.

During interview with the Memory Care Director on at 12:00 PM, she acknowledged that the resident was not always served meal items as she received a pureed diet provided by the kitchen. She stated the staff in the secured unit served the resident what the kitchen delivered as pureed. The soup and brownie had not been received in a pureed form.

These findings were discussed with the Food Service Manager at 1:00 PM on . He acknowledged that the residents were supposed to be served all of the meal items in the secured unit and that he had not received any requests from staff in the secured unit for missing meal items for Resident #10.

The approved meal items had not been served to Resident #10 who received a pureed diet and substituted meal items of equal nutritional value had not been served as a replacement. No substituted meal items were documented at this time for this resident. These findings were acknowledged by the Administrator during interview on at 3:45 PM.

Class III