STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	**06/07/2018**
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#2018004640), for The Brookshire Assisted Living Facility located at 85 Bulldog Blvd Melbourne, Florida 32901, license number 7354, was conducted on through . There was deficient practice on the date of the survey.

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

Based on interview and record review the assisted living facility failed to ensure residents who were and required assistance with activities with daily living received physical and occupational , , per physician orders, for 2 of 29 (Resident #1 and Resident #2) sampled residents. The facility failure to provide the ordered , , services resulted in subsequent for the sampled residents posing a direct threat to the safety, security and wellbeing of the residents.

Findings Include:

In an interview with Resident #1 on at 12:57 PM, Resident #1 stated that since being admitted to the facility that he has not received any physical , , or occupational , , as prescribed by his Primary Care Physician. Resident #1 also reported he had several and no interventions have been put in place to stop him falling again.

Record review of Resident #1 Health Assessment (AHCA form 1823) dated noted Resident #1 was required physical , , and occupational , , due to left side prior to his admission date of . Also, found during Resident #1 Record Review was a new prescription of physical , , and occupational , , dated on . Further review of the record revealed that Resident #1 had a on and again on . (Photographic evidence obtained)

In an interview with the Director of Nursing (DON) at 4:51 PM on she stated, "I can't state what happened to that as to why he didn't get it in , , I'm not going to make up anything, I do not know why" Resident #1 did not received , , services after his admission. The DON confirmed that she did not follow up with Resident #1's case manager to ensure he received the physician ordered , , services after his insurance did not cover the in house , , provider services.

On at 1:00 PM, an interview was conducted with Resident #2. Resident #2 stated that she has suffered about four . Resident #2 stated that she had her last , last month when she out of bed because her bed was unsteady and she has to maneuver carefully in order not again. Resident #2 stated that she does not receive physical , , , and that she would like to receive that service.

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On , a record review Resident #2's Health Assessment (AHCA form 1823) dated . Resident was admitted to the facility on . The assessment identified Resident #2 as a precaution, and suffering from recurrent . According to a progress note in the residents file, it was found that the resident suffered on , , , and .
In an additional review of Resident #2's file revealed a physician order dated for occupational and physical , . There was no documentation in the file that the , services were initiated.

On at 2:25 PM, an interview was conducted with the Administrator. The Administrator stated the home health agency came out on and assessed Resident #2 and "We just called the home health agency today ( ) and found out that they did not pick her up". "We have to get with the doctor today."

On at 2:28pm an interview with the , Director, who stated he communicates with the DON related to , services denials and he stated he does not have any documentation for Resident #1 and Resident #2's insurance coverage denial because he "knows for a fact that the insurance will not pay for the Physical , ."

On at 4:50 pm, an interview was conducted with the facility DON. The DON admitted that prior to today, she nor none of her staff followed up with the insurance once the resident was denied, and no other services were provided in regards to the resident not receiving physical , . DON also stated that she was unable to provide any documentation in regards to the denial of physical , .

Class II

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

Based on observation, interview and record review the assisted living facility failed to honor resident rights by implementing the facility's grievance policy after being notified of a resident's grievance related to /neglect. The facility also failed to provide a clean and decent living environment free from extended pungent odor for facility residents that resided on the third floor.

Findings Included:

In an interview with Resident #1 on at 12:57 pm, he stated he on the floor in the middle of the night as he was attempting to go to the . Resident #1 stated he was on the floor all night from 11 pm until 7 am until the next shift came on. Resident #1 stated that his neighbor Resident #4 heard his

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cry for help and tried to retrieve staff from all three floors with no help. Resident #1 stated once his neighbor could not find any staff he requested to be left alone on the floor with a pillow and blanket until staff could assist. Resident #1 stated that a male staff member helped him off the floor but could not recall his name from the next shift. On at 6:30 pm, Resident #1 was re interviewed regarding his he stated that there was no follow up from administration regarding his .

Record review of Resident #1's Health Assessment (AHCA form 1823) dated on noted Resident #1 has left side and needs assistance with ambulating, personal care, transferring and toileting with one person assist hands on.

In an interview with the Administrator on at 7:15 pm, she stated that a Department of Children and Families investigator came to the facility on to investigate allegations of and neglect for Resident #1's on . The Administrator stated she could not find the facility's grievance investigation for Resident #1's . The Administrator stated she needed to complete an in house investigation related to and neglect when the Department of Children and Families initiates an investigation of resident .

In an interview with Staff G on at 1:34 pm, she stated that Staff H and Staff M assisted her in a 3-person assist of Resident #1 off the floor on at 3:50 am. Staff G stated she completed the incident report documenting the on for Resident #1. She also stated that administration did not follow up with her related to the until , at which point she completed a Witness Statement.

Record Review of Staff G's Witness Statement revealed that Staff G completed a Witness Statement related to Resident #1's on .

A review of the grievance log revealed the last entry was dated , there were no entries documented regarding Resident #1's investigation of /neglect allegations of his on .

The Facility grievance policy dated revealed the facility failed to comply with the following grievance procedures:
1. Within 2 business days after the submission of written complaint, a status report shall be provided by the resident to the complainant.
2. Within 7 days after the submission of the written complaint, the residence will give the complainant and if applicable the designated person a written decision explaining the residence investigation finding and action to be taken for resolution. On , an initial facility tour was conducted at 10:00 AM of the third floor. A pungent odor that appeared to be was present on the Avalon hall located on the

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north hall of the third floor. The odor remained along the hall throughout the time of the survey from 10:00 AM until the last tour at 5:00 PM.

On . . . . . at 10:00 AM an interview was conducted with Employee K. Employee K stated that many of the residents on the Avalon hall required personal care that included diapers changes. Employee K stated the many of the residents wet the bed all the time, need lots of assistance and has bad accidents that require a shower afterwards. Employee K stated, "It's just me and the other girl and we are the only one on the floor and we have about 30 people each. It's difficult to pass meds and provide care at the same time."

On at 5:32 PM, an interview was conducted with the Administrator who stated the facility was aware of the odor on the third floor and stated the odor comes from about five residents that are excessive bed wetter's on the Avalon hall.

Class III