STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932514	R 08/29/2018
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 revisit to complaint investigation #2018004640 was conducted on and . The Brookshire license #7354 had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility failed to ensure 1 of 7 sampled residents (#6) had a completed health assessment that addressed all the required information.

Findings:

Resident record review for resident # 6 revealed he was admitted to the facility on . The health assessment report dated did not have the medical license, phone number and address of the healthcare provider who completed the form.

In an interview on at 4 PM with the Director of Clinical Services stated the form was overlooked.

Class III

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

Based on observations, record review and interview the facility retained 1 of 7 sampled residents (#6) that had a pattern of in common areas and furniture.

Findings

In an interview on at 10:30 AM with resident #5 who said there was a man from the 3rd floor (name) that urinates all over the place, the library and the furniture. So they took the nice furniture away and now they have chairs to sit on in the common areas because he on them. "Maybe he should go where there are people like him. He is unsteady on his feet, can't talk too good".

In an interview on at 11 :30 AM with resident #7 there was a man on the 3rd floor that all over the place. He has gotten better about wearing briefs lately but he made the place smell bad, and they took the nice furniture away because it had .

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In an interview with resident #10 at 2: 30 PM who said, as he pointed to resident #6 that he all over the place, the place smelled badly. They took the furniture away and now they have dining to sit in the library or the common area.

In an interview with resident #11 on at 2: 40 PM who said, as he pointed to resident #6 and said something needed to be done about him. He continued to urinate where ever he wanted. The place smelled of and that bothered him and everyone else.

In an interview on at 3 PM with the resident's mental health worker from the VA clinic, who said the resident had experienced a change in behavior (publicly). She explained that she was evaluating the resident's appropriateness to living in an assisted living facility.

During a tour of the facility's third floor on at 5:25 PM a strong and pungent smell of lingered on the Avalon hallway.

Resident record review for resident # 6 admitted revealed a health assessment report form 1823 dated that listed diagnoses of memory loss, bowel incontinence, ( ) - non-military, ataxia and speech . He was independent in eating and transfers; supervision was needed with ambulation, dressing, toileting and assistance with bathing and . He needed assistance with self -administration of medications.

In an interview on at 4:42 PM with the administrator /Director of Nursing who said she spoke with the resident's sister, regarding his increased level of care and the VA nurse agreed. The sister was told she would be given a 45 day notice of discharge. The resident refused to wear adult briefs, but lately had become more accepting.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on observations, record review and interview the facility failed to provide a clean and decent living environment free from strong odor from 1 resident (#6) who on furniture and carpets and that was offensive to the other residents.

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Findings:

In an interview on at 10:30 AM with resident #5 who said there was a man from the 3rd floor (name) that all over the place, the library and the furniture. So they took the nice furniture away and now they have chairs to sit on in the common areas because he on them. "Maybe he should go where there are people like him. He is unsteady on his feet, can't talk too good".

In an interview on at 11:30 AM with resident #7 who said there was a man on the 3rd floor that all over the place. He had gotten better about wearing briefs lately but he made the place smell bad, and they took the nice furniture away because it had .

In an interview with resident #10 on at 2: 30 PM who said, as he pointed to resident #6 that he all over the place, the place smelled badly. They took the furniture away and now they have dining to sit in the library or the common area.

In an interview with resident #11 on at 2: 40 PM who said, as he pointed to resident #6 and said something needed to be done about him. He continued to urinate where ever he wanted. The place smelled of and that bothered him and everyone else.

In an interview on at 3 PM with the resident's mental health worker from the VA clinic, who said she was evaluating the resident's appropriateness from assisted living.

During a tour of the facility's third floor on at 5:25 PM a strong and pungent smell of lingered on the Avalon hallway.

In an interview with the administrator on at 5:45 PM who said the smell on the third floor must have been that the staff were changing resident (s).

Class III

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

Based on record review and interview the facility did not maintain an up to date Medication Observation Record (MOR) for 2 of 7 sampled records (4 and 5).

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Findings:

Resident record review for resident #5 revealed a revised health assessment form 1823 dated that listed diagnoses of ( ), ( ), ( ) and ( ). He needed assistance with self-administration of medications.

The continued review revealed the 2018 Medication Observation Record (MOR) listed - 100 milligrams (mg), 81 mg, and 60 mg all once daily one daily were blank on , Lantus 40 Units daily was blank on and .

The MOR listed 100 mg, 81 mg, 60 mg and Tradjenta 5 mg and D 3 100 Units daily were blank on 100 mg 3 times daily at 9 AM, 2 PM and 9 PM was blank on 8/3, and at 9 PM. It was blank on at 2 PM. 40 mg at bedtime was blank on 8/3 and .

The review revealed no notations that indicated why the medications were not given/taken.

Interview with resident #5 on at 10:30 AM who said she did not have any concerns with her medications, she always got them.

In an interview on at 3:30 PM with the Director of Clinical Services who stated the staff must have not signed the MOR.

Record review for resident #4 revealed a sliding scale order dated that noted:
flexpen inject before meals and at bedtime per sliding scale:
151-200=2 units (u)
201-250=4U
251-300=6U
301-350=8U
351-400=10U
Greater than 400 12U

Review of the MOR for and revealed there were days when the result of the Sugar (BS) test noted per sliding scale was required and the amount of given was left blank as follows:
-BS was 361 at 2100 no was marked as given-10 U were required
-BS was 384 at 2100 no was marked as given-10 U were required

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-BS was 208 at 2100 no was marked as given-4 U were required
-BS was 152 at 0600 no was marked as given-2 U were required
BS was 165 at 2100 no was marked as given-2 U were required
BS was 250 at 2100 no was marked as given 4 U were required
BS was 261 at 2100 no was marked as given 6 U were required
BS was 180 at 1130 no was marked as given-2 U were required
Further review of the MOR revealed there were blank spaces on the MOR, there was no way to determine if the sugar test or was given, some examples are as follows:
On at 1630-Left blank
On and and 8/3 at 2100 spaces all left blank

On at 5 PM, the director of clinical services said that she did not know why the spaces were left blank.

On at 5:20 AM resident #4 said she was aware of the amount of that she was required and she always received it on time.

Class III

E205 - ECC - Health Assessment - 58A-5.030(6) FAC

Based on record review and interview the facility failed to ensure that once receiving Extended Congregate Care (ECC) services, a new health assessment was obtained at least annually for 1 resident (#8) in a sample of 7 who received ECC.

Findings:

Resident record review for resident #8 revealed a health assessment report 1823 dated that listed diagnoses that included . According to the report he needed total assistance with ambulation and toileting, supervision with eating and assistance with bathing, dressing, and assistance with self-administration of medications. The review revealed no evidence the resident had a new health assessment report annually.

In an interview on at 3:20 PM with the administrator/Director of Nursing who stated the resident was able to transfer with assistance but was unable to assist with ADLs. She had not enrolled the resident in ECC, although he was getting the care he needed.

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Class III

E206 - ECC - Service Plans - 58A-5.030(7) FAC

Based on record review and interview the facility failed to ensure that before receiving Extended Congregate Care (ECC) services, the extended congregate care administrator or manager developed a preliminary service plan and within 14 days of receiving services, the ECC administrator or manager developed written service plan for 1 of 7 sampled residents (#8).

Findings:

During the facility entrance on at 9:30 AM the administrator stated none of the residents received ECC services.

Resident record review for resident #8 revealed a health assessment report 1823 dated that listed diagnoses of , , ( ), high , and . Per report he needed total assistance with ambulation and toileting, supervision with eating and assistance with bathing, dressing, and assistance with self-administration of medications.

A facility nursing data collection form dated and completed by a Licensed Practical Nurse (LPN) indicated the resident needed total assistance with hygiene, nail care, dressing and toileting.

Facility notes dated on , 3/3, 3/4, , indicated the resident was not able to transfer/pivot and was unable to assist with care. Note dated indicated the resident needed to be assessed for skilled nursing facility placement, was a 3 person assist with transfers and total care with activities of daily living (ADLs).

In an interview on at 3:20 PM with the administrator/Director of Nursing who stated the resident was able to transfer with assistance but was unable to assist with ADLs. She had not enrolled the resident in ECC.

Observations on at 9:45 AM noted the resident with some difficulty while receiving assistance transferring from the wheelchair to bed.

Class III