STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964787	01/15/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE JENSEN BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1700 NE INDIAN RIVER DRIVE** **JENSEN BEACH, FL 34957**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2018015501, was conducted on at Brookdale Jensen Beach. The facility had deficiencies at the time of the survey.

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

Based on interview and record review, it was determined the facility failed to provide care and services appropriate to meet the needs of each resident to prevent and to update the residents record to reflect any precaution interventions implemented by the facility, for 1 of 3 sampled residents (Resident #3).

The findings include:

The facility's Prevention and Management policy and procedure indicated staff are to complete a Post Evaluation Form for each that occurs and to note any individualized interventions that were considered. This post evaluation is "part of the resident record." The interventions identified are to be implemented, documented in the resident record and on the personal service plan.

Review of Resident #3's health assessment, dated , indicated special precautions as risk and requires supervision. The comments section on page 2 of this form reflected Resident #3 is at high risk for and has poor safety awareness. The Activities of Daily Living (ADLs) section notes the assistance of 1 staff member is required for all ADLs except eating.

The progress note, dated at 10:49 AM, indicated Resident #3 was found on floor in front of bed. States she cannot remember how she got out of bed. noted to be on floor around resident's 911 was called. EMT/Paramedics turned resident around and a was noted on resident's left , , along with on right and left . Resident #3 complains of , to right but able to move and rotate on command. Resident transported to hospital. Daughter/POA (Power of Attorney) notified. Physician notified via fax.

The progress note, dated at 11:14 AM, indicated Resident #3 was found by staff sitting on bathroom floor in another resident's room. Resident #3 was able to move all extremities. Resident with no complaints of , or discomfort noted. No apparent injuries at this time. Resident assisted to wheelchair. Daughter made aware. Home Health Agency and facility management made aware.

During interview and review of Resident #3's record conducted with the HWD (Health and Wellness

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Director), on beginning at approximately 1:00 PM, she was asked if a new Personal Service Plan was developed for this resident due to the number of at this facility. She replied, the Personal Service Plan dated , was the only one that she could locate. She was asked why this copy was not signed by staff, resident, or resident's representative. She stated she could not find the signed copy in this resident's closed record so she printed it from the computer. She was asked if any new risk prevention interventions were put in place for Resident #3 post . She replied she could not find that documentation in this resident's closed record and she was not working here until . She asked the Activity Director for Memory Care if she was familiar with any interventions that were put in place for this resident (post). The Activity Director for Memory Care stated she did not know. The HWD acknowledged that the Personal Service Plan indicated a Post Evaluation is supposed to be completed after each resident's and individualized interventions to prevent further are to be addressed and this is to be a part of the resident's record. She acknowledged this documentation could not be located for Resident #3. The HWD could not locate any documentation to reflect risk prevention interventions were updated post multiple for Resident #3.

Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation and interview, it was determined the facility failed to post in a common area where residents normally congregate, in the Memory Care Unit, an activity calendar.

The findings include:

During observation of the Memory Care Unit and interview conducted with the HWD (Health and Wellness Director), on beginning at approximately she acknowledged the activity calendar was not posted in its usual place (on the wall in the dining room). The HWD then proceeded to ask the Activities Coordinator for Memory Care where the , activities calendar is located. She replied the calendar was taken down with the Christmas decorations and that they are in the process of putting up the Valentine's Day decorations. The Activities Coordinator for Memory Care acknowledged the , activities calendar was not currently posted or available to the residents on this unit.

Class III