STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965054	R 03/19/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE NORTHDALE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3401 WEST BEARSS AVENUE** **TAMPA, FL 33618**	

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

0000 - Initial Comments

Assisted Living Facility

A revisit to a complaint (CCR 2018016849) was conducted at Brookdale Northdale on in conjunction with a complaint investigation (CCR 2019000996). Brookdale Northdale had a deficiency at the time of the visit.

(License #9500)

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

Based on record review and interview, the facility failed to provide documented evidence of care and services appropriate to the needs of residents were provided to minimize with injuries for one (Resident #1) of three residents whose records were reviewed.

Findings included:

A review of Resident #1's record revealed a series of beginning on . The resident was hospitalized after a on after hitting their and returned to the facility on .

Resident #1's record reflected beginning again on with an unwitnessed indicating that the resident was wearing non-slip shoes and again on with the notation that they were wearing non-slip shoes. There was no documentation of ongoing interventions that were put in place in an attempt to minimize/prevent future . On , the record indicated that the resident and broke their right , and . The resident subsequently had surgery on the right , and went in to rehabilitation. Resident #1's record showed that the resident returned to the facility on .

A review of Resident #1's record showed their most recent health assessment form dated that indicated that the resident had a history of and was a risk. Resident #1's record showed that on , the resident was found on the floor wearing non-slip socks. An email from Resident #1's power of attorney (POA) indicated that the resident broke their left , , left , and sustained several small to the . The email also stated that Resident #1 would not be returning to the facility due to safety concerns (photographic evidence obtained). There were no interventions documented in Resident#1's record, after the resident returned to the facility on , as to what the facility would be do in an attempt to prevent reoccurrences.

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An interview was conducted with the health and wellness director (HWD) concerning what was done to help prevent/minimize for Resident #1. The HWD stated that they kept the resident in a common area and provided a document entitled CARE Profile dated with written notes concerning precautions and a Personal Service Plan dated that listed potential interventions to reduce risk (photographic evidence obtained). The HWD acknowledged that there was no documentation of interventions that were actually put in place after the resident suffered the various .

Class III