STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964787	04/02/2019
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 #2019001167, was conducted on - at Brookdale Jensen Beach, License #9294. The facility had related deficiencies identified at the time of the investigation.

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

Based on observation, record review and interviews, the facility failed to monitor the continued appropriateness of residency in this assisted living facility (ALF) for 2 out of 3 sampled residents (Residents #1 and #2).

The findings included:

1. On at 11:00 AM, the Health and Wellness Director (HWD) stated during interview that Resident #1 was discharged from the facility in . The resident's representatives had removed the resident from the facility, and the facility had not issued a discharge notice to the resident.

Review of the resident's record revealed the following documentation of , on the resident:
a. Open Area Flow Sheet dated documents a " right heel", , identified on . Flow sheets completed on , and document that the right heel , is " ".
b. Open Area Flow Sheet dated documents a "suspected , , " on the resident's left heel identified on . A flow sheet dated documents the left heel as a "pressure injury". There was no documentation to show the stage of this , .
c. A medical examination conducted on and documented on AHCA Form 1823, used to determine a resident's appropriateness for ALF continued residency, shows a health care provider's assessment of a "right heel ". There was no documentation of the resident's left heel , or of the stage of either of the heel .

During interview with the HWD at 12:00 PM on , she confirmed that the resident had two , at the time of discharge, one on each heel with the right heel as an , . The resident was not appropriate for continued residency in an ALF based on the , that was not improving within 30 days, and the identification of an , . She acknowledged that the administration had discussed the resident's appropriateness for continued residency at the facility, but stated that the facility had not provided the resident's representative with a discharge notice.

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2. On at 11:00 AM, the Health and Wellness Director (HWD) stated during interview that Resident #2 had a current , on her . She stated that the facility had not determined that this resident was inappropriate for continued residency in an ALF , and had not issued a discharge notice to the resident. The resident had been admitted to hospice on .

At 12:30 PM on , Resident #2 was observed being assisted out of bed by an aide. During interview with the Licensed Practical Nurse (LPN) and the aide at this time, they stated that the resident is assisted out of bed three times a day for meals and is seated in a wheelchair in her room for a maximum of one hour. During interview with the resident at this time, she was not able to give an accurate self-report due to , .

Review of the resident's record revealed the following documentation of , on the resident:

a. Health Care Provider's order dated for an evaluation and treatment of " decubiti ". A note dated from the Home Health Agency (HHA) Registered Nurse (RN) shows this was healed.
b. An Open Area Flow Sheet dated documents a "pressure" identified on with no stage of the noted. A flow sheet completed on documents that this , on the resident's (tail bone area) is a " , ".

The "Hospice Coordination of Services" document that was presented by the HWD as the interdisciplinary care plan that specifies the services being provided by hospice and by the facility starting revealed the following:

a. Assist with care "daily"
b. Escort and Mobility (transferring the resident from bed to chair)-"daily"

A plan of care for staff at the ALF to follow related to the resident's extensive care needs, with interventions to prevent further and to address care, could not be identified in this plan of care. The plan did not indicate additional care instructions for ALF staff to adhere to in order to prevent additional , or to enhance the healing of the current , .

The resident's last medical examination completed by a health care provider on AHCA Form 1823 dated documents that the resident requires no assistance with any activities of daily living (ADLs), including ambulation, transfers, bathing, toileting and grooming. The assessment also documents that the resident has no , .

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Although Resident #2 was determined to be [redacted] ill and was admitted to hospice with a start of care date on [redacted], the resident's extensive care needs with a nonhealing [redacted] deemed this resident inappropriate for continued residency at this ALF.

These findings were discussed with the HWD on [redacted] at 1:00 PM. She confirmed that Residents #1 and #2 had not been given a notice of discharge at any time since the onset of the [redacted] and [redacted]. There was insufficient documentation indicating the coordination and provision of care and services by ALF staff in conjunction with hospice to ensure continued residency. Additionally, Resident #2 did not have a new medical examination completed on AHCA Form 1823 after encountering a significant change. The facility provided no additional documentation for review at this time.

Class III