STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964916	02/27/2017
NAME OF PROVIDER OR SUPPLIER **BROOKDALE WEST BOYNTON BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **8220 JOG ROAD** **BOYNTON BEACH, FL 33437**	

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

0000 - Initial Comments

Two unannounced licensure complaint surveys, CCR# 2016013311 and #2016013974, were conducted on at Brookdale West Boynton Beach (Lic #9384) and completed on . The facility had deficiencies identified at the time of the investigation.

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

Based on resident record review and staff interview, the facility failed to
1) Have accurate and fully-completed health assessments for 3 of 3 residents whose health assessments were reviewed. (Residents #1, #2, and #3), and
2) Determine continued residency upon an assessment of the needs of the resident in accordance with facility policy for 2 of 3 residents (#1 and #2)

The findings include:

1a) On , a review was conducted of Resident #1's Health Assessment (AHCA 1823), dated . On top right of page 1 of the Assessment (AHCA Form 1823), the Resident's weight at the time of the assessment was not recorded.

In Section 1-A, Health Assessment/Activities of Daily Living, it was documented that Resident #1 was "Independent" with eating, toileting and transferring, and needed "Supervision" with ambulation. The "Comments" in Section 1-A were not completed with clarification as to the extent and type of supervision and/or assistance for those areas of Activities of Daily Living which required supervision or assistance.

Interview was conducted with LPN on at 11:09 AM. She stated, "[Resident #1] did not eat independently. The aides, or sometimes the resident's granddaughter, would assist in feeding [Resident #1] her meals."

According to nurse's notes, Resident #1 was using a wheelchair in of 2016, with note on that Resident was unable to transfer from wheelchair to chair. This inability to transfer would have also her ability to be independent with toileting.

A new, updated health assessment was not completed to show the significant change in Resident #1's level of assistance/supervision in ADL's

In Section 2 - A, Self-Care and General Oversight, check marks were not placed in the appropriate columns, along with additional comments, to signify the extent Resident #1 was able to perform each of

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the self-care tasks.

In Section 2-B, Part B, there is no documentation to signify whether Resident #2 needs help with taking their medication, or whether the resident needs assistance or administration.

1b) On , a review was conducted of Resident #1's Health Assessment (AHCA 1823), dated . On top right of page 1 of the Assessment (AHCA Form 1823), the Resident's weight at the time of the assessment was not recorded.

In Section 1-A, Health Assessment/Activities of Daily Living, there is no indication as to the extent to which Resident #2 is able to perform Self-Care . Also, the "Comments" in this section were not completed with clarification as to the extent and type of assistance for those areas of Activities of Daily Living which required assistance.

In Section 2 - A, Self-Care and General Oversight, there were no additional comments added, to signify the extent Resident #1 was able to perform each of the self-care tasks which required assistance.

Review of Nurse's Notes reveal Resident #2 had a decline in cognition and was moved to Memory Care on due to need for increased supervision.

1c) On , a review was conducted of Resident #3's Health Assessment (AHCA 1823), dated . Resident #3's height and weight listed on page 1 are: Height = 5 ft, 4 inches, Weight = 137. It is noted that Nursing Notes dated upon Admission, , document resident's height at 5 ft, 5 inches, and 161 lbs. There is no explanation given as to the 24 lb difference in weight within a 24 hour period.

In Section 1-A, Health Assessment/Activities of Daily Living, the "Comments" in this section were not completed with clarification as to the extent and type of supervision and/or assistance for those areas of Activities of Daily Living which required supervision or assistance.

In Section 2-B, Part B, it is documented that Resident #3 needs help with their medication; however, there is no indication as to whether Resident #3 needs assistance with self-administered medication or medication administration.

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An interview was conducted with HWD on at 5:30 PM. She acknowledged the need for updated Health Assessments for accuracy and the completion of missing documentation for these residents.

2a) On , during review of the facility's incident log from 2016 to , 2017, it was noted that there was no listing on the Incident Report of a with injury for Resident #1 which had occurred on .
A fax cover sheet, dated , from the Wellness Nurse to Resident's primary care physician (PCP) documented, "Resident found on the floor [with] bloody face. Transferred to [local hospital]."
Nurse's notes in Resident #1's chart, dated , documents, "Resident found on the floor in her bloody face. 911 was called and resident was transported to [local hospital]. Daughter and PCP notified."
There is no documentation that Resident #1 was assessed, post , or that an investigation had been completed with interventions put into place.

2b) On at 8 PM, Resident #2 had an unwitnessed without injury. This was not recorded on incident log, and there is no documentation of a post investigation being conducted with additional interventions put into place.

A review of the Facility's Policy & Procedure for Management documents: "A is defined as any drop, collapse, or tumble. Any witnessed or reported unwitnessed with or without injury is reported in the [Facility's] Incident Reporting System. Residents who sustain a should have a post investigation completed with interventions identified to reduce the potential for future and injury."

On at 6:10 PM, the Health & Wellness Director and Executive Director were informed that Resident #1's on and Resident #2's on could not be found on the Facility's Incident Report.
The ED and HWD both acknowledged these were not recorded on the Incident Log, nor had post investigations been completed with interventions identified and put into place.

Class III

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on resident record review and staff interview, the facility failed to arrange services for physician

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ordered lab tests, for 1 of 3 sampled residents (Resident#3).

The findings include:

During record review for Resident #3, a Physician order dated for , ( ), Complete Panel (CMP), Analysis with Culture and Sensitivity (UA w/C&S), /Thyroxine (/FT4), and Lipid Panel was found within the section for "Physician's Orders".
Upon further review, there was no documentation found within Resident #3's chart showing evidence that the lab work ordered on was completed.

On at 5:15 PM, this surveyor asked the Health and Wellness Director (HWD) to produce documentation showing the labs ordered on were completed. On at 6:00 PM, the HWD stated, "I have checked [Main lab used for testing] and another lab occasionally used by the facility, and there is no record these labs ordered on for [Resident #3] were ever completed."

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on facility record review and staff interview, the facility failed to ensure adequate staffing in the Memory Care Unit on 2 days, per written work schedule that reflects its 24 hour staffing pattern for 2 week period.

The findings include:

During review of written staffing schedule and actual staff hours worked for - , it is noted that on and , Resident Care Aide (RCA) #1 was scheduled to work the 11:00 PM to 7:00 AM shift, but did not work the assigned hours on each of these dates.

Interviews were conducted with the Health and Wellness Director (HWD) and Executive Director (ED) on at 2:55 PM. It was brought to their attention that the staffing schedule showed RCA #1 was to work 11 PM - 7 AM on and , but she had not clocked in on those dates.

The HWD and ED spoke with RCA #1, via telephone, on at approximately 3:00 PM. RCA #1 confirmed she was scheduled to work on and , but had called out; she couldn't provide

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the name of the person with whom she had spoken.

Both the ED and HWD confirmed, after speaking with RCA #1, there were 2 days during the past week that the Memory Care Unit had only 1 Resident Care Aide during the 11 PM -7 AM shift. The HWD stated, "No one at the facility (Nurse or the the other RCA scheduled on this date) notified me or [the ED] that the scheduled care staff had not showed up for her shift." This resulted in the Memory Care Unit being understaffed, according to the facility staffing schedule, on these two dates. The HWD added, "This is the first we are aware of the situation."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and staff interview, the facility failed to file an incident report regarding the transfer of 1 of 3 sampled residents from the facility to a unit providing more acute care [hospital] due to the incident [suspected] rather than the resident's condition before the incident [suspected] (Resident #1).

The findings include:

On , during review of the facility's incident log from 2016 to , 2017, it was noted that there was no listing on the Incident Report of a with injury for Resident #1 which had occurred on .

A fax cover sheet, dated , from the Wellness Nurse to Resident's primary care physician (PCP) documented, "Resident found on the floor [with] bloody face. Transferred to [local hospital]."
Nurse's notes in Resident #1's chart, dated , documents, "Resident found on the floor in her bloody face. 911 was called and resident was transported to [local hospital]. Daughter and PCP notified."

On at 6:10 PM, the Health & Wellness Director and Executive Director were informed that Resident #1's on could not be found on the Incident Report given for the past 6 months. The ED and HWD both acknowledged Resident #1's with injury was not recorded on the Incident Log, nor had an initial Adverse Incident report been filed.

Class III