Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965424	A. BUILDING: _____ B. WING _____	09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LAKE ORIENTA	217 BOSTON AVENUE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint Investigation #2019011429 was conducted on . . . . . Brookdale Lake Orienta had deficiencies at the time of the visit.	A 000		
A 030 SS=G	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	A 030		

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A 030	Continued From page 1 (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical	A 030		

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A 030	Continued From page 2 by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the	A 030		

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A 030	Continued From page 3 resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . , , ... for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set	A 030		

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A 030	Continued From page 4	A 030		

forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident ' s access to a telephone to call the State Long-Term Care Ombudsman

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A 030	Continued From page 5 Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27(1)(a), FS Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, observations and interviews, the facility directly threatened the physical health and safety of residents by failing to properly ensure the security of the building and the operation of the facility's emergency "pendents". Findings: On at 5:01 AM, entry into the building was obtained through an unlocked front door. All	A 030		

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A 030	Continued From page 6 four floors along with an unsecured nurse's station was observed. The nursing office, located within the nurse's station, was open, and had records and other materials for anyone to see. Staff was not seen working on any of the floors. One resident sat by the dining room waiting for breakfast. While at the nurse's station, a staff member came into the station to pick up supplies. On at 5:01 AM, the facility swimming pool was seen. Both doors to the pool, from a common area walk-way were unlocked. Upon entering the pool area, there was a surface film of leaves on the top of the water in the pool. The emergency equipment was rolled into the corner of the pool deck along with a garden hose. On at 5:25 AM, after knocking, ringing the bell, and shouting through the space between the secured doors, the Memory Care Unit was entered. Staff C and D were working there. Neither staff member questioned who the surveyor was, but they freely provided information. On at 7:55 AM, the administrator stated he did not know why the front door was unsecured, and did not know why the swimming pool area was unsecured. The administrator was not able to provide any explanation on the process for securing either the front door of the facility or access doors to the swimming pool. On . . . . . at 2:15 PM, the Administrator and Wellness Coordinator were unable to provide an operating procedure or incident log regarding the swimming pool. On at 7:55 AM, with the Administrator and Wellness Coordinator, the Wellness Coordinate stated she supervises the resident	A 030		

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A 030	Continued From page 7 care staff, medication technicians and nurses. She stated she works a couple of week end days and occasionally comes in overnight. On . . . . . at 8:40 AM, the pool area was unlocked, and the safety equipment pushed into a pile in the corner of the pool deck. On . . . . . at 7:10 AM, resident #1 stated the staff never respond when called. Resident #1 stated his emergency pendent does not work. Resident #1 was asked to push the emergency pendent to determine if it was working, and check staff response time. After the emergency pendent was pushed, it lite up as being active. After waiting 16 minutes, resident #1 did not receive a response from staff. On . . . . . at 7:55 AM, the Administrator and Wellness Coordinator stated they were alarmed the response time was so long when the emergency pendent was pushed for resident #1. The Wellness Coordinator stated the goal is 12 minutes. The administrator stated they do not have direct access or knowledge to when an emergency pendent is pushed. The administrator stated they can run a report, but they would need to do that daily to know if a response time was unacceptable. Neither the Administrator or Wellness Coordinator could confirm when they reviewed the emergency pendent response time report. The administrator stated when the emergency pendent is pushed by a resident, it sends a message to the staff walkie-talkie with the resident and their location. The staff assigned to the resident is expected to respond and if helping another resident they are to all for a -up staff to respond. On at 7:37 AM, staff D stated that no one	A 030		

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A 030	Continued From page 8 responded to resident #1 because "the facility was busy". On at 7:56 AM, staff J stated the emergency pendent response time is 15 minutes. On at 8:09 AM, staff K stated the emergency pendent rings the walkie-talkies. "If it is your resident and you can not respond you are to call a -up." Staff K stated the response time is supposed to be 15 minutes. On at 9:45 AM, staff M stated they were trained the response time is 5 minutes. On at 9:51 AM, staff N stated they were told they needed to respond within 5 minutes. The facility's operating procedure regarding "Resident Call System", dated , reflected that the "pendents" are to be answered in a "timely" manner. The policy reflected that the maintenance of the emergency devices is handled by the maintenance supervisor. The procedure reflected that the Maintenance Coordinator is to routinely check the equipment, test the system monthly, and communicate failures to the Wellness Coordinator. On at 8:50 AM, the maintenance supervisor stated he does not have any responsibility regarding the emergency call system. On at 2:15 PM, with the Wellness Coordinator, the Administrator stated they were not aware that the Maintenance Coordinator was to maintain the emergency call system for the facility.	A 030		

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A 030	Continued From page 9 On . . . . . at 11:35 AM, resident #2 stated she on and when she at 4:45 AM, she pushed the pendent, but no one came to help her. Resident #2 stated she yelled out but could not get any help. Resident #2 stated her friend came at 8 AM to bring her coffee and found her lying on the floor. Resident #2's file reflected that she on in her apartment. Resident #2 stated she pushed the emergency pendent but did not get a response for two hours and was found only after a friend stopped to bring her coffee. Resident #2's file reflected that she was transported to a local medical facility for a higher level of care after the . On at 2:15 PM, the Administrator and Wellness Coordinator stated they are aware of the emergency pendent situation with resident #2. The administrator stated he is unable to pull call reports to , of 2019, so he can not dispute the time frame. On . . . . . at 9 AM, resident #5 stated he found resident #2 lying on the floor of resident #2's room. Resident #5 stated the front desk was called and a staff member responded to resident #2's room. Resident #5 stated the nurse called 911 and then left the room with the resident on the floor, stating they were busy. Class II	A 030		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgrnt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and	A 165		

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A 165	Continued From page 10 reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the	A 165		

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A 165	Continued From page 11 identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and	A 165		

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A 165	Continued From page 12 are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to file an adverse incident report for 1of 5 residents after a . which required the resident be moved to a higher level or care (#2). Findings: On at 11:35 AM, resident #2 stated she . on . . . . and when she at 4:45 AM, she pushed her emergency pendent, but no one came to help her. Resident #2 stated she yelled out but could not get any help. Resident #2 stated her friend came at 8 AM to bring her coffee and found her lying on the floor. Resident #2's file reflected that she on in her apartment, and was transported to a local medical facility for a higher level of care.	A 165		

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BROOKDALE LAKE ORIENTA	217 BOSTON AVENUE ALTAMONTE SPRINGS, FL 32701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 13 On at 3:08 PM, the family of resident #2 stated their mother in her apartment on . The family stated resident #2 told them she at 4:45 AM. The family stated resident #2 pushed her emergency pendent and no one responded. The family stated she was found by her friend at 8 AM. The family stated the friend contacted the front desk and a nurse responded to resident #2's apartment and called 911. The family stated the friend told the family the nurse stated she was busy and was providing medication to other residents, and did not stay with the resident. On at 9 AM, resident #5 stated he found resident #2 lying on the floor of Resident #2's apartment. Resident #5 was not sure of the date. Resident #5 stated the front desk was called to get the nurse. Resident #5 stated 911 was called. Review of the agency adverse incident reporting system (AIRS) did not provide any documentation of the facility filing an adverse incident report related to the of resident #2. On at 2:15 PM, the Administrator and the Wellness Coordinator stated they are aware of the emergency pendent situation regarding resident #2. The administrator stated he is unable to pull the call reports to , of 2019 so he can not dispute the time frame related to the emergency pendent for resident #2. The administrator stated he is aware the facility failed to file an adverse incident report. Class III	A 165		