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
	AL11922279	A. BUILDING: _____ B. WING _____	01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTBROOKE GARDENS	201 SUNSET DRIVE CASSELBERRY, FL 32707

(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 Complaint Investigation #2019020133 was conducted on [redacted]. Eastbrooke Gardens had a deficiency identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to adequately supervise 2 of 3 sampled residents who were involved in a physical altercation (#1 & 2). Findings: Observations made of resident #1 at 9:55 a.m. on revealed she had a purple crescent-shaped on her that extended from her outer left down to her left nostril. She was alert but non-verbal. The director of nursing was present and said resident #2 was sitting behind resident #1 in the activity room when he hit her from behind. At 10:58 a.m. on , caregiver A said that on at approximately 10 a.m. she was walking towards the activity room, she heard a "slap" and saw resident #1's go but she could not see someone actually hitting her. She said as she got closer, she heard a "slap" again and saw resident #1's go again	A 025		

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A 025	Continued From page 2 and that was when she saw resident #2 hitting resident #1 in her from behind. She yelled for help and other staff arrived to assist her. She said resident #1 was taken to the nurse's station to be evaluated. Resident #1's record revealed a facility admission date of . A current 1823 health assessment form, dated , indicated that her diagnoses include front . A facility note, dated , indicated that she was hit on the left side of her by another resident who was sitting behind her in the activity room. She was removed from the activity room and brought to the nurse's station. She had redness and purple discoloration on her cheeks and under her left . Her left lower was . A , was ordered on and the results indicated that she had a possible nondisplaced of the bone. Resident #2's record revealed a facility admission date of . A current 1823, dated , indicated that his diagnoses include . A facility note, dated , indicated that he hit a female resident who was sitting in front of him in the activity room. He was unable to explain the reason why. Review of the facility's camera footage with the administrator and business office manager revealed the following: At 9:04 a.m., resident #2 was brought into the activity room. At 9:05 a.m., an unknown caregiver entered the room then left. At 9:06 a.m., an unknown caregiver entered the room then left.	A 025		

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A 025	Continued From page 3 At 9:07 a.m., an unknown caregiver brought resident #1 into the room, placed her in front of resident #2, then left the room at 9:09 a.m. At 9:12 a.m., an unknown caregiver entered the room then left at 9:15 a.m. At 9:20 a.m., the activity director entered the room, looked around, then immediately left. At 9:21 a.m., the activity director entered the room twice and immediately left each time. At 9:25 a.m., resident #2 hit resident #1 four times. At 9:27 a.m., the activity director entered the room then immediately left. At 9:29 a.m., the activity director entered the room then immediately left. From 9:31 a.m. to 9:34 a.m., resident #2 hit resident #1 multiple times. At 9:36 a.m., the activity director entered the room, assisted a resident with finding a seat, then immediately left. From 9:37 a.m. to 9:40 a.m., resident #2 hit resident #1 continuously on her right arm and . . . . The activity director and caregiver A could then be seen entering the room and removing both residents. Following the viewing, the administrator said he never viewed the camera footage but rather he spoke with the director of nursing, a hospice nurse, and the business office manager. The business office manager said she viewed the footage only until the 9:26 a.m. mark and both said they did not know resident #2 continued to hit resident #1 after that. Both resident #1 and #2 have a diagnoses of . . . . . and they both reside in a secured memory care facility. Resident #1 is non-verbal and therefore, unable to call out for help; she sustained injuries during the altercation.	A 025		

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A 025	Continued From page 4 Class II	A 025		