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 _____	11/20/2020

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 Complaint Investigation #2020017454 was completed on . . . . . Brookdale Lake Orienta had a deficiency found 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 shall notify a licensed physician when a resident exhibits signs of or . . . . . or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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. (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 record review and interviews, the facility failed to maintain a general awareness of a resident's whereabouts to ensure safety of physical and emotional well-being, and failed to maintain personal supervision as appropriate for each resident (#1). Findings: Resident #1's 1823 revealed a medical history including . . . , ... , aphasia, right-sided . . . ,and . . . . Resident #1's record, dated . . . . . , reflected that the resident had been sleeping in the same bed as resident #2 during the course of the evening without staff's knowledge. Staff did not become aware of	A 025		

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A 025	Continued From page 2 resident #1's whereabouts until they were notified by resident #2's family that upon review of the surveillance camera in resident #2's room, that resident #1 was in resident #2's bed at 3 AM that morning. The family of resident #2 stated they wanted resident #1 removed from resident #2's room immediately. The medical record revealed that resident #1 was not seen by a physician until . . . . . because the resident never complained about an injury. The record reflected that the physician observed the resident on and there was a on the right arm and scratches on the left arm. On , resident #1's power of attorney stated he went to the facility that morning the day of the incident, , and the resident informed him that staff F grabbed her arm and she on the floor. He also stated there was a on her arm. He stated he alerted the administrator the morning of the incident, and the administrator stated that staff F incurred an injury from the struggle and not the resident. He stated the administrator and staff admitted they were not aware of resident #1's whereabouts at the time, and that she was sleeping in resident #2's bed. He stated resident #1 incurred a on her arm from the staff grabbing her to get her out of the room. On at 4:30 PM, staff F confirmed she and the staff were unaware resident #1 had entered resident #2's room in the middle of the night, and that she was sleeping in bed with resident #2. She confirmed staff learned about resident #1's whereabouts at 3 AM when the family of resident #2 called to say they reviewed the surveillance camera and saw resident #1 in bed with resident #2. She also confirmed when she went to take resident #1 out of resident #2 's	A 025		

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A 025	Continued From page 3 room, resident #1 became angry when asked to leave the room and began to hit the staff member, and staff F grabbed the resident's underarm and pushed her out of the room. She stated that resident #2's Power of Attorney had requested that resident #1 not go into resident #2's room during nighttime hours and when resident #2 is trying to sleep or nap. On at 10:30 AM, staff A confirmed the staff, including the overnight staff, tries to redirect and reflect the residents from having intimacy. She stated most of the time they want to sit next to each other and walk around together. She stated resident #2's daughter complained that resident #1 would wake resident #2 up during the night and at bedtime, and she didn't want that encouraged. She confirmed the staff was unaware of resident #1's whereabouts when the incident happened. She also confirmed resident #1 was not seen by the physician until days later when resident #1's family complained about the injury. On . . . . . at 10 AM, the administrator confirmed the findings above. Class II	A 025		