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
	AL11964072	A. BUILDING: _____ B. WING _____	08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST MELBOURNE	7300 GREENBORO DRIVE MELBOURNE, FL 32904

(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 A complaint investigation #2021011368 was conducted on [redacted] and [redacted]. Brookdale West Melbourne had deficiencies at the time of the visit.	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 [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 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		

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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 observations, record reviews and interviews, the facility failed to provide adequate supervision to 1 of 5 sampled residents who eloped from the facility (#1). Findings: While conducting a complaint investigation at one of this facility's sister facilities, a review of resident #1's record revealed the resident was admitted to the sister facility on . She resided in that facility's secured memory care unit. The resident's current 1823 assessment form, dated , indicated her diagnoses included , type 2,	A 025		

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A 025	Continued From page 2 and Documentation in the resident's record revealed the following: A hospital ED note, dated , indicated the resident was seen for possible COVID-19 exposure. On at 9:02 p.m., she arrived at the COVID special isolation unit (SIU), which was a unit set up in this facility. On at 8:15 p.m., she was found by staff just outside of the SIU building in the parking lot. She was inside a staff member's car going through the belongings in the car. She was escorted inside. The door alarm was functioning properly, the caregiver heard the door alarm, saw another resident near the door, and did not realize it was resident #1 who went out. On , resident #1 was discharged from the SIU and returned to the sister facility. On at 10:53 a.m. resident #1 was seen walking with staff in the sister facility's memory care unit. The resident initially made contact but then quickly looked around. Her affect was flat, and she did not engage in conversation. On at 12:42 p.m., the sister facility's administrator said that at the time of resident #1's elopement she was the health and wellness director of the sister facility. She said when the elopement occurred, two staff, who were not working in the SIU, saw out of a window resident #1 walking in the parking lot, so they informed SIU nurse D. SIU caregiver C thought the door alarm was set off by another resident and not by resident #1. This administrator said the SIU was	A 025		

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A 025	Continued From page 3 not secured and said nurse D and caregiver C were the only two staff working on that evening in the SIU. On . . . . . at 1:04 p.m., caregiver C said she did work in the SIU on and remembered resident #1 but said she did not remember the resident ever eloping. On at 2:32 p.m. resident #1 was seen walking in the hallway alone. At times she used the hall railing. She wore tennis shoes. Her pace was fast, and her gait was shuffled. She went into , which was another resident's room, and laid down on the bed. On at 4:45 p.m., the door used by resident #1 to elope was observed. The door was labeled as door number 146 and was located near resident . A pond was located approximately ten . . . from the door. On . . . . . at 5 p.m., nurse A said that on the night resident #1 eloped, he did not work on the SIU but heard an alarm sound. He looked outside and saw a car door open. He thought someone was breaking into a car, so he went outside. He then realized it was a resident from the SIU. On at 5:10 p.m., nurse B said that on the night resident #1 eloped, he was walking across the street when he saw a female sitting in a car. The car's headlights were flashing and although it was not raining, the windshield wipers were on. He found it strange, so he walked over to the car and realized it must've been a resident. He said the resident had the car keys in the . . . . He knocked on the outside door to the SIU and spoke with caregiver C, who identified resident #1 and said it was her own car the resident had been	A 025		

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A 025	Continued From page 4 in. Caregiver C said she left her keys in the car and the door unlocked because she did not want to take her keys into the COVID unit. On . . . . . at 3:28 p.m., caregiver C said she now remembered that resident #1 did in fact elope from the SIU. The caregiver could not remember the time, but said she was in another resident's room when she heard the door alarm sound. She looked outside and did not see anyone. She closed the door. About two minutes later, two men came to the door and said there was a woman outside in a car. She went to check herself and saw resident #1 sitting in her car with her car keys. She said she must have left her car door unlocked. She said her keys were in the nurse's station and she was not sure how the resident got them. She could not remember whether the nurse's station door had been locked. She brought resident #1 . . . into the facility and she did not see any injuries on the resident. She told nurse D what happened. The caregiver said prior to the elopement, the resident did not want to stay in her bed and continuously walked around the unit. She said the resident had been trying to leave and was pushing on the door prior to actually exiting out of the door. On . . . . . at 10:03 a.m., nurse D said she worked on the SIU on from 3 p.m. to 3 a.m. She initially said she could not remember anything from that night. When the note she wrote was read to her regarding resident #1's elopement on , she said she did recall the situation but could not remember what the resident's behavior was like prior to the elopement and could not remember anything else about the incident. On at 11:18 a.m., the administrator of this	A 025		

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A 025	Continued From page 5 facility said he received a call on . . . . from corporate telling him a COVID SIU needed to be set up at this facility because quite a few residents from the sister facility's memory care unit tested positive for COVID. He said the sister facility provided all the staffing for the unit and the only thing this facility did was provide the residents with their meals. On at 12 p.m., caregiver E said she worked the SIU on . . . . . from 7 a.m. to 1 p.m. She said resident #1 walked around the unit and always tried to get out of the door. The caregiver had to keep redirecting the resident. She said even when the resident was in the sister facility's memory care unit where she previously resided, the resident did the same thing. On . . . . . at 1:15 p.m., this facility's administrator said the only thing he knew about resident #1's elopement was that on the evening of , nurse A called him to report the incident, so the administrator called the sister facility's administrator, who handled everything from there. The facility's administrator did not complete any follow-up investigation and did not implement any measures to prevent further elopements because the residents living on the SIU, including resident #1, were the responsibility of the sister facility. Class II	A 025		
CZ821 SS=G	59A-35.110 FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any	CZ821		

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CZ821	Continued From page 6 change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections; and, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities:	CZ821		

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CZ821	Continued From page 7 Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at:	CZ821		

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CZ821	Continued From page 8 https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500.	CZ821		

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CZ821	Continued From page 9 (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the agency, a preliminary report within 1 business day and a full report within 15 days of 1 of 5 sampled residents eloping from the facility (#1.) Findings: While conducting a complaint investigation at one of this facility's sister facility, a review of resident #1's record revealed the resident was admitted to the sister facility on [redacted]. She resided in that facility's secured memory care unit. The resident's current 1823 assessment form, dated [redacted], indicated her diagnoses included [redacted] type 2, [redacted] and [redacted]. Documentation in the resident's record revealed the following: A hospital ED note, dated [redacted], indicated the resident was seen for possible COVID-19 exposure.	CZ821		

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CZ821	Continued From page 10 On . . . . . at 9:02 p.m., she arrived at the COVID special isolation unit (SIU), which was a unit set up in this facility. On . . . . . at 8:15 p.m., she was found by staff just outside of the SIU building in the parking lot. She was inside a staff member's car going through the belongings in the car. She was escorted . . . inside. The door alarm was functioning properly, but the caregiver heard the door alarm, saw another resident near the door and did not realize it was resident #1 who went out. On . . . . . , she was discharged from the SIU and returned to the sister facility. On at 10:53 a.m. resident #1 was seen walking with staff in the sister facility's memory care unit. The resident initially made , contact but then quickly looked around. Her affect was flat, and she did not engage in conversation. On at 12:42 p.m., the sister facility's administrator said that at the time of resident #1's elopement she was the health and wellness director of the sister facility. She said when the elopement occurred, two staff, who were not working in the SIU, saw out of a window resident #1 walking in the parking lot, so they informed SIU nurse D. SIU caregiver C thought the door alarm was set off by another resident and not by resident #1. This administrator said the SIU was not secured and said nurse D and caregiver C were the only two staff working on that evening. On . . . . . at 1:04 p.m., caregiver C said she did work in the SIU on and she remembered resident #1 but said she did not remember the resident ever eloping. On at 1:15 p.m. this facility's	CZ821		

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CZ821	Continued From page 11	CZ821		

administrator said the only thing he knew about resident #1's elopement was that on the evening of .. .... nurse A called him to report the incident, so the administrator called the sister facility's administrator, who handled everything from there. In addition, this facility's administrator did not complete any follow up investigation nor implement any measures to prevent further elopements because the residents living on the SIU, including resident #1, were the responsibility of the sister facility.

On .. .... at 4:45 p.m., the surveyor looked at the door used by resident #1 to elope. The door was labeled as door 146 and was located near resident . A pond was located approximately ten ... from the door.

On .. .... at 5 p.m., nurse A said that on the night resident #1 eloped he did not work on the SIU. However, he heard an alarm sound, looked outside, and saw a car door open. He thought someone was breaking into a car, so he went outside. He then realized it was a resident from the SIU.

On at 5:10 p.m., nurse B said that on the night resident #1 eloped, he was walking across the street when he saw a female sitting in a car. The car's headlights were flashing and although it was not raining, the windshield wipers were on. He walked over to the car then realized it was a resident. He said the resident had the car keys in the . He knocked on the outside door to the SIU and spoke with caregiver C, who identified resident #1 and said it was her own car the resident had been in. Caregiver C told him she left her keys in the car and the door unlocked because she did not want to take her keys into the COVID unit.

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CZ821	Continued From page 12 On at 3:28 p.m., caregiver C said she now remembered that resident #1 did in fact elope from the SIU. The caregiver could not remember the time, but said she was in another resident's room when she heard the door alarm sound. She looked outside, did not see anyone, and closed the door. About two minutes later, two men came to the door and said there was a woman outside in a car. She went to check herself and saw resident #1 sitting in her car with her car keys. She said she must have left her car door unlocked. She said her keys were in the nurse's station and she was not sure how the resident got them. She could not remember whether the nurse's station door had been locked. She brought resident #1 into the facility and did not see any injuries on the resident. She told nurse D what happened. The caregiver said prior to the elopement, the resident did not want to stay in her bed and continuously walked around the unit. She said the resident had been trying to leave and was pushing on the door prior to actually exiting out of the door. A review of the facility's documentation binder, provided by the administrator, did not contain documentation to indicate the facility electronically submitted to the agency, a preliminary report within 1 business day and a full report within 15 days of the resident's elopement. On at 9:40 a.m., the administrator said the required reports were not submitted to the agency because he considered resident #1 to be a resident of and responsibility of the sister facility. On at 1:15 p.m., this facility's administrator said the only thing he knew about	CZ821		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST MELBOURNE	7300 GREENBORO DRIVE MELBOURNE, FL 32904

(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
CZ821	Continued From page 13 resident #1's elopement was that on the evening of nurse A called him to report the incident, so the administrator called the sister facility's administrator, who handled everything from there. This facility's administrator did not complete any follow-up investigation and did not implement any measures to prevent further elopements because the residents living on the SIU, including resident #1, were the responsibility of the sister facility. Class II	CZ821		