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 _____	10/07/2021

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 #2021013806 was conducted on [redacted]. Brookdale Lake Orienta had deficiencies at the time of the visit.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the	A 010		

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A 010	Continued From page 1 resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced	A 010		

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A 010	Continued From page 2 practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care	A 010		

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A 010	Continued From page 3 practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by:	A 010		

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A 010	Continued From page 4 Based on record review and interview, the facility failed to ensure a health assessment (AHCA form 1823) was obtained after a significant change for 2 of 4 sampled residents (#3 & 4). Findings: 1. Resident #3's record revealed an admission date of . His most recent health assessment form was dated and included diagnoses of , , and , , . Review of the facility incident reports revealed a note from at 9:30 PM that documented a with that resulted in admission to the hospital. Review of facility progress notes revealed resident #3 returned from the hospital on and had a left and , , . The record did not contain an updated assessment form following the hospital admission. Photographic evidence was obtained. On at 2:30 PM, the administrator confirmed they did not have an updated assessment form after resident #3 returned from the hospital. 2. Resident #4's record revealed an admission date of . His most recent assessment form was dated and included diagnoses of , , and noted to be at risk for . He was not noted to be at risk for elopement on the assessment form. A review of his admission health assessment, dated , revealed he was at risk for elopement on admission to the facility. Resident #4 lived in the memory care unit of the facility. Review of facility reports and progress notes found resident #4 eloped from the facility's secured memory care unit on 2	A 010		

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A 010	Continued From page 5 occasions in 2021. A progress note from a facility nurse, dated at 1:03 PM, revealed he was found "outside the building". Another progress note, dated , from an agency nurse revealed that resident #4 was missing at 7:30 AM. After a search throughout the facility, police were called. The resident was found by police at 9:45 AM, 1.6 miles away from the facility. He was returned without injury. An updated health assessment was not found in the resident's record following his elopements. Photographic evidence was obtained. On10/07/21 at 4 PM, the administrator and the regional nurse coordinator agreed that updated health assessments were needed. They confirmed they did not have an updated assessment for resident #3 and resident #4 following their significant events. Class III	A 010		
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	A 025		

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A 025	Continued From page 6 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 Resident Care Standards. 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. (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.	A 025		

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A 025	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on record review, facility report review, and interview, the facility failed to provide adequate supervision, including maintaining a general awareness of a resident's whereabouts for 1 of 4 sampled residents who eloped from the facility on two separate occasions for 1 of 4 sampled residents (#4), failed to maintain written documentation and updates for significant changes which required medical attention for 3 of 4 sampled residents (#1, 2 & 3), and failed to follow a healthcare provider's order for a , for 1 of 4 sampled residents (#1). Findings: 1. Resident #4's record revealed an admission date of . His most recent health assessment was dated and included diagnoses of 's , , , and noted to be at risk for . His admission health assessment, dated , revealed he was at risk for elopement on admission to the facility. He was not noted to be at risk for elopement on the assessment. Resident #4 lived in the memory care unit of the facility. Review of facility reports and progress notes reflected that resident #4 eloped from the facility's secured memory care unit on 2 occasions in 2021. As noted on a progress note from a facility nurse dated at 1:03 PM, he was found "outside the building". Another note dated at 9:26 AM was not signed but indicated the resident had been "found in the dining hall" on . The facility report noted the resident was found on at 1:30 AM outside the memory care doors but did not indicate if it was inside or outside the building.	A 025		

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A 025	Continued From page 8 On . . . . . at 11:04 AM, a note from an agency nurse revealed that staff were unable to find resident #4 at 7:30 AM. The nursing director was notified, a search was started inside and outside the building, and the police were called. Review of the police report revealed police responded to a call from the facility on at 8:29 AM regarding missing resident #4. The regional nurse manager provided a photo and description of the resident's clothing. Twelve (12) officers and the resident's son were involved in the search. Police sent a reverse 911 call out with a description of the resident. At 9:25 AM, the manager of a hotel reported he saw the resident. The hotel was 1.6 miles from the facility and involved walking on a very busy 6 lane divided highway and then down a 2 to 4 lane road, past 2 bodies of water and several businesses. The hotel manager stayed with resident #4 until police arrived and brought the resident . . . . to the facility at 9:45 AM. A tour of the memory care unit on at 2:15 PM with the unit coordinator found resident #4 was not wearing an ID bracelet. When asked, he said he did not know where it was. A search in his room found it was on a bookshelf near his bed. The memory care coordinator brought the ID to the resident and put it on his arm. On at 1:20 PM, the regional nurse manager confirmed the sequence of events regarding the elopement of resident #4. 2. Resident #1's record revealed an admission date of . . . . . . His current health assessment was dated and included diagnoses of 's . . . . . and . . . . . He required assistance with all activities of daily	A 025		

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A 025	Continued From page 9	A 025		

living (ADLs) and medications. He was admitted to hospice care on . A progress note, dated ..... at 12:30 PM, reflected the resident had an unwitnessed in the bathroom. He was found on his and his was . Emergency Medical Services ( ) was called but the resident refused first aid from the paramedics and refused to be taken to the hospital. The note indicated the facility would "continue to monitor". The next observation note in the record was dated over 1 month later on , when the resident had another unwitnessed . There was no documentation that the facility monitored the well-being of resident #1 following a with injury to the .

On at 11:20 AM, the resident was observed seated on the edge of his bed. He said he had no , , and everything was good. He did not have any bandages or , on his arms or . He did not remember having a recently.

3. Resident #2's record revealed an admission date of . His current health assessment was dated and included diagnoses of , , , and . He required assistance with all ADLs except he was able to eat independently and required assistance with medications. A facility report documented resident #2 had an unwitnessed on at 6:30 AM. He told the caregiver after the and denied any , . The facility notified the family and his healthcare provider. On ..... at 6:45 PM, a nurse documented the resident did not have any , or issues. On ..... at 8 PM, a caregiver noted the resident's right was and warm to the touch. was called and brought him to the emergency room (ER). On at

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A 025	Continued From page 10 10 AM, the hospital reported a and to the right . He returned to the facility with a , and orders to follow-up with his primary care provider in days and with an orthopedic , on . The orders noted to "keep , on at all times until cleared by your doctor". A progress note on at 10 AM from the regional nurse manager indicated "a right and , per ER" and the facility would be contacting rehab "due to needing 24/7 care with ADLs". On at 12:56 PM, the resident refused transfer to rehab. On at 4:39 PM, a note documented the resident had trouble breathing and was weak. Vitals signs were taken, and was called. The resident refused to go to the hospital. The note read, "will continue to monitor". The next note was a late entry on at 3:45 PM which reflected that the resident was found on the floor "by the bed/bathroom" on at 11:43AM. Scrapes were noted on both . Staff documented, "Will continue to monitor". There were no monitoring notes found regarding care and observation of the , , observation following , and observations regarding or . There were no notes regarding follow-up , with his healthcare provider and an orthopedic , . 4. On at 11:30 AM, resident #3 said he remembered a in , because his , medications were too strong, and he lost his balance after standing up. He said he stays active and often uses the stairs. Resident #3's record revealed an admission date of . His current health assessment was dated and included diagnoses of , , , and , , . He required supervision with all ADLs except was	A 025		

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A 025	Continued From page 11 able to eat and dress independently. He required assistance with medications. Facility notes documented on ..... the resident called the front desk to report he had a and wanted to go to the hospital. A note on ..... at 2:57 PM from the Health and Wellness Director reflected that the resident reported a .. and was sent to the hospital. He returned from the hospital on with ..... and , ... On at 1:15 PM, a progress note read, "Day 1 2 Return from hospital." No additional notes regarding monitoring or care after were found. On ..... , a note indicated the resident was coughing and wanted to call . Staff wrote, "Will continue to monitor". The next note was dated ..... at 11:32 AM in which the resident was sent to the hospital with signs and symptoms of severe and body aches. No further notes were found. It was unknown if the resident was either admitted to the hospital or when he returned. On ..... at 1:20 PM, the regional nurse manager stated she believed the residents were being monitored, but confirmed documentation was not being maintained by the staff on a regular basis. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support	A 032		

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A 032	Continued From page 12 and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises,	A 032		

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A 032	Continued From page 13 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to make, at a minimum a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number, and did not ensure staff were generally aware of the location of all residents assessed at high risk for elopement at all times for 1 of 4 sampled residents (#4). Findings: Review of the facility's elopement book found 16 of the 16 residents in memory care were assessed to be at risk for elopement. A tour of the memory care unit on at 2:15 PM with the unit coordinator found resident #4 was not wearing an identification (ID) bracelet. When asked, he said he did not know where it was. A search in his room found it was on a bookshelf near his bed. The memory care coordinator brought the ID to the resident	A 032		

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 _____	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 032	Continued From page 14 and put it . . . on his arm. Resident #4's record revealed an admission date of . His most recent assessment was dated . . . . and included diagnoses of , , , and noted to be at risk for . . . He was not noted to be at risk for elopement on the assessment. A review of his admission health assessment dated revealed he was documented to be at risk for elopement on admission to the facility. Resident #4 lived in the memory care unit of the facility. Review of facility reports, and progress notes found resident #4 eloped from the facility's secured memory care unit on 2 occasions in 2021. As noted on a progress note from a facility nurse dated . . . . at 1:03 PM, he was found "outside the building". Another progress note dated . . . . . from an agency nurse documented resident #4 was missing at 7:30 AM. After a search throughout the facility, police were called. The resident was found by police at 9:45 AM, 1.6 miles away from the facility. He was returned without injury. An updated health assessment was not found following with elopement for resident #4. On at 2:25 PM, the unit coordinator stated she checks every day when she is working but confirmed she did not document her checks for ID. She said some of the residents remove the ID and hide them. She stated the nurses document IDs in the computer. When asked to review the daily documentation for ID on at 3:28 PM, the regional nurse manager stated she told the nurses to start the process of a minimum daily monitoring for ID after resident #4 eloped. She confirmed daily monitoring and documenting for the	A 032		

Agency for Health Care Administration

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A 032	Continued From page 15 presence of ID . . . . for elopement risk residents was not being done. Class III	A 032		