

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965818	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/08/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE LAKE MARY

**150 MIDDLE STREET
LAKE MARY, FL 32746**

(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 Investigations #2021014492, #2021015044 and #2021016200) were conducted from . Brookdale Lake Mary 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 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 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	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 reviews and interviews, the facility failed to provide proper supervision in the Memory Care Unit by leaving the unit unattended for all residents and preventing 2 of 2 residents (#1 & #2) from exiting their room and entering the common area. Findings: Resident #1's health assessment revealed a diagnosis of advanced . Resident #2's health assessment revealed a diagnosis of . Resident #1 and resident #2 shared a room in the memory care unit (MCU) on .	A 025		

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A 025	Continued From page 2 The facility staff schedule for _____ and _____ confirmed staff A was the only staff and caregiver assigned to the MCU on _____ between the hours of 11 PM-7 AM. The Law Enforcement report, dated _____, reflected that staff A was tasked to provide supervision to the residents in the MCU. Resident #1 and resident #2 both resided in the same room in the MCU. Sometime between midnight and 7 AM, the staff used shoelaces to tie around the exterior door handle to a nearby handrail, resulting in resident #1 and resident #2 not being able to open the door and leave their room will. At approximately 7 AM, staff B came to work and discovered the tied door handle. The Department of Children and Families (DCF) report, dated _____ confirmed staff B discovered resident #1 and resident #2's door tied shut with a shoelaces in the MCU. Both residents were asleep in their rooms at the time of the incident, locking the residents in their room. Staff B confirmed staff A was the only caregiver working in the MCU that evening. She confirmed it was against protocol to tie the residents' door shut. The facility's report of the incident reflected that staff A was terminated, and that she denied knowing anything about the incident. It confirmed staff A was the only caregiver in the MCU, and staff A stated she left the MCU to go to the third floor of the assisted living side to use the laundry machines. She denied tying the shoelaces on the door handle. The job description for caregivers in the memory care unit reflected that caregivers are not allowed	A 025			

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A 025	Continued From page 3 to leave the MCU unattended at any time. Corrective measures included in-service education regarding and neglect. Community resident wellness checks were conducted on On at 10 AM, staff I confirmed she works the overnight shift from 11 PM to 7 AM, and worked the overnight shift on She stated staff A was the only caregiver in the MCU that night and the staff is aware they cannot leave the MCU unattended at any time. She confirmed the overnight shift in the MCU always has only one staff member. She stated she did not witness the shoelaces around the door handle as she never entered the MCU that night. However, she heard about the incident from the wellness director. She stated there is a laundry room in the MCU, so there is no reason to go to the third floor assisted living side to use the washing machines. On at 10 AM, the administrator confirmed the wellness director who witnessed the incident was no longer employed at the facility. She also confirmed there is only one caregiver in the MCU on the overnight shift with two staff on the assisted living side. She stated staff A was the only caregiver in the MCU on the overnight shift on, and both resident #1 and resident #2 were asleep in their beds at the time of the incident. Staff A was terminated for leaving the MCU unattended and using a shoelaces to prevent resident #1 and resident #2 from leaving their room. Class II	A 025			
A 030 SS=D	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures	A 030			

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A 030	Continued From page 4 59A-36.007 (5) 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 59A-36.006, 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. (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 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities;	A 030		

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A 030	Continued From page 5 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 standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (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. 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	A 030		

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A 030	Continued From page 6 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 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	A 030		

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A 030	Continued From page 7 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 must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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	A 030			

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A 030	Continued From page 8 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 Program or local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and _____, Rights Florida. 429.27 Property and personal affairs of	A 030		

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A 030	Continued From page 9 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 _____ under state law, _____ or _____ 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 reviews and interviews, the facility failed to provide a safe and decent living environment, free from _____ and neglect for all residents in the memory care unit. Findings: Resident #1's health assessment included a diagnosis of advanced _____. Resident #2's health assessment included a diagnosis of _____. Resident #1 and Resident #2 shared a room in the memory care unit (MCU) at the time of the incident. The facility staff schedule for _____ and confirmed staff A was the only staff and caregiver assigned to the memory care unit on _____ between the hours of 11 PM-7 AM.	A 030			

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A 030	Continued From page 10 The Law Enforcement's report, dated _____, reflected that staff A was tasked to provide supervision to the residents in the MCU. Resident #1 and resident #2 both resided in the same room in the MCU. Sometime between midnight and 7 AM, the staff used shoelaces to tie around the exterior door handle to a nearby handrail, preventing resident #1 and resident #2 from opening the door and leaving their room. At approximately 7 AM, staff B came to work and discovered the tied door handle. The Department of Children and Families (DCF) report, dated _____, confirmed staff B discovered resident #1 and resident #2's door tied shut with a shoelace in the memory care unit. Both residents were asleep in their rooms at the time. Staff B confirmed staff A was the only caregiver working MCU that evening. She confirmed it is against protocol to tie the residents' door shut. This investigation was submitted with verified findings to support maltreatment of inadequate supervision. The facility's report of the incident reflected that staff A was terminated and she denied knowing anything about the incident. It confirmed staff A was the only caregiver in the MCU and staff A stated she left the MCU to go on the third floor of the assisted living side to use the laundry machines. She denied tying the shoelace on the door handle. The facility's job description for caregivers in the MCU reflected that caregivers are not allowed the unit attended at any time. Corrective measures included in-service education regarding and neglect. Community resident wellness checks were conducted on _____.	A 030			

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A 030	Continued From page 11 On _____ at 10 AM, with staff I confirmed she works the overnight shift from 11 PM to 7 AM, and worked the overnight shift on _____. She stated staff A was the only caregiver in the MCU that night, and that staff are aware they cannot leave the MCU unattended at any time. She confirmed the overnight shift in the MCU always has only one staff member. She stated she did not witness the shoelace around the door handle as she never entered the MCU that night. However, she heard about the incident from the wellness director. She stated there is a laundry room in the MCU, so there is no reason to go on the third floor assisted living side to use the washing machines. On _____ at 10 AM, the administrator confirmed the wellness director who witnessed the incident was no longer employed at the facility. She also confirmed there is only one caregiver in the MCU on the overnight shift with two staff on the assisted living side. She stated staff A was the only caregiver in the MCU on the overnight shift on _____, and both resident #1 and resident #2 were asleep in their beds at the time of the incident. Staff A was terminated for the incident of leaving the MCU unattended and using a shoelace to prevent resident #1 and resident #2 from leaving their room. Class III	A 030		
CZ821 SS=D	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 12 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. (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: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15	CZ821			

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CZ821	Continued From page 13 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: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780 , and through the Agency's adverse incident reporting system which can only be	CZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965818	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/08/2021
NAME OF PROVIDER OR SUPPLIER BROOKDALE LAKE MARY			STREET ADDRESS, CITY, STATE, ZIP CODE 150 MIDDLE STREET LAKE MARY, FL 32746		
(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 14 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. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission.	CZ821			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965818	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/08/2021
NAME OF PROVIDER OR SUPPLIER BROOKDALE LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 150 MIDDLE STREET LAKE MARY, FL 32746		
(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 15 (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 review and interview, the facility failed to complete a 1-day and 15-day incident report to the Agency for Health Care Administration for 1 of 1 resident (#1). Findings: Facility notes for resident #1 revealed on _____, resident #1 had an unwitnessed _____ in the bathroom of the resident's room. Emergency Medical Services (_____) was called and the resident was transported to the emergency room (ER). The resident received 3 staples to the _____. The resident returned from the ER to the facility the same day. On _____, the _____ was removed from the resident's _____ and _____ was noted to the _____ of the _____. On _____ at 10 AM, the administrator stated she was working in the memory care unit the day of the incident and the _____ was unwitnessed. She stated she was not aware that a 1-day or 15-day incident report was required for this incident. Class III	CZ821		