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
	AL11964948	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DR PHILLIPS MC	8015 PIN OAK DR. ORLANDO, FL 32819

(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 Relicensure survey with Limited Nursing Service (LNS), Complaint Investigation #2022002053, and a Generator Monitoring were conducted on . . . . and . . . . . Brookdale Dr Phillips Memory Care had deficiencies at the time of the survey.	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,	A 010		

AHCA Form 3020-0001

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

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A 010	Continued From page 1 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 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	A 010		

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced 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 , 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	A 010		

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A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care 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	A 010		

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A 010	Continued From page 4 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: Based on observations, record reviews, and interviews, the facility retained 2 of 5 sampled residents who exceeded the continued residency criteria in an Assisted Living Facility (ALF) by requiring total assistance with activities of daily living (ADLs) and with transferring (#8 & #9). Findings: 1. Resident #8's record revealed a facility admission date of . A current assessment 1823 form, dated , indicated the resident's diagnoses included , , , and , , . The document indicated the resident was non-verbal, had extreme and required assistance ADLs. The resident's record revealed the following documentation: at 4:13 p.m., the resident no longer met hospice criteria and was discontinued from those services. at 12:20 p.m., a facility care conference note indicated the resident had increased needs for transferring and ADLs, and required 2-person assist at all times. Notes on at 6:09 p.m., at 3:23 p.m., at 3:26 p.m., and at 2:41 p.m. all indicated the resident was non-verbal, of and , wheelchair dependent, and required assistance with ADLs and transferring.	A 010		

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A 010	Continued From page 5 On . . . . . at 11:49 a.m., staff B said resident #8 required total assistance with ADLs and transferring. On . . . . . at 10:22 a.m., staff I said resident #8 required total assistance with ADLs and transferring. On . . . . . at 10:53 a.m., the Memory Care supervisor said resident #8 required total assistance for approximately one year and she knew the resident was no longer appropriate for continued residency. She tried to get the resident admitted to two different hospice providers, but both indicated the resident did not meet the criteria for admission. A representative from a third hospice provider was expected to come to the facility to evaluate the resident for appropriateness for hospice. Observations made during a transferring of resident #8 on at 1p.m. revealed the resident was in a wheelchair that was positioned parallel to the bed. Staffs A and E placed their arm under each of the resident's arms. They used the of the resident's pants to lift her from the chair to the bed. The resident's , were closed throughout the entire process, and she did not participate. In addition, the staff provided total care to the resident following the transfer. 2. Resident #9's record revealed a facility admission date of . A current assessment 1823 form, dated . . . . , indicated the resident's diagnoses included and . The document indicated the resident used a wheelchair for ambulation, was moderately . . . . , and required assistance with ADLs.	A 010		

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A 010	Continued From page 6 Facility notes, dated [redacted], and [redacted], all indicated the resident was of [redacted] and [redacted], wheelchair dependent, 2-person assist with transferring, and required assistance with ADLs. On [redacted] at 10:22 a.m., staff I said resident #9 required total assistance with ADLs and transferring. On [redacted] at 10:56 a.m., the supervisor said resident #9 began declining the summer before. She said the resident was only able to brush her own and hair, take her pills, and feed herself. On [redacted] at 11:23 a.m., staff A said resident #9 required total assistance with ADLs and transferring. On [redacted] at 11:49 a.m., staff B resident #9 required total assistance with ADLs and transferring Observations made during a transferring of resident #9 on at 1:14 p.m. revealed staffs A and E used the same technique and process as they did with resident #8. They also provided total [redacted] care for this resident. 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 [redacted] or has a change of condition	A 025		

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A 025	Continued From page 7 in order to rule out the presence of an underlying physiological condition that may be contributing to such [illegible] or [illegible]. 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 [illegible] 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 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	A 025		

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A 025	Continued From page 8 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 care and services appropriate to meet the needs of residents by failing to provide adequate supervision to 1 of 5 sampled residents who eloped from the facility on two separate occasions (#1). Findings: Resident #1's record revealed a facility admission date of . . . . . An assessment 1823 form, dated , indicated the resident's diagnoses included . . . . . and . . . . . ( ). The form indicated the resident was an elopement risk. The record revealed the following documentation: A care profile, dated . . . , indicated the resident made attempts to exit the building without supervision. On . . . . . , the resident was exit-seeking. On . . . . , the resident was exit-seeking.	A 025		

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A 025	Continued From page 9 On . . . . at 6:12 p.m., the resident was very agitated and difficult to be redirected after his family brought him . . . . to the facility. He was trying to open every door on each hallway. On at 3:02 p.m., an employee who worked in the separately licensed assisted living facility (ALF), located next to this facility, saw the resident walking in the parking lot. Upon further investigation, it was determined the resident pushed through a patio screen and climbed out. The patio door was then locked. Staff were instructed to check on the resident every fifteen minutes for the next 24 hours. On at 2:31 p.m., the resident was found at a public school by the school's resource officer, who returned the resident to the facility. The outside courtyard gate's door lock was broken, and the door was open. It was assumed the resident broke the lock then exited the facility. A service plan, dated . . . . . , indicated the resident made attempts to exit the facility without supervision. On . . . . at 1:10 p.m., staff F said that on . . . . . she saw the resident during breakfast between approximately . . :30 a.m. She did not see the resident exit-seeking on that day, and said the facility door that exited to the courtyard was kept unlocked during the day shift. On at 1:49 p.m., staff E said that on . . . . . she last saw the resident during breakfast. On at 2:15 p.m., staff G said when she arrived to work on . . . . . at 2 p.m., she saw the resident sitting in the TV room. She later	A 025		

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A 025	Continued From page 10	A 025		

heard a door alarm while she was giving a shower to another resident but, she could not leave that resident to investigate the alarm.

On [redacted] at 2:27 p.m., staff H said that when she arrived to work on at 2 p.m., she went to check on the resident, who was in his room. She later heard a door alarm and when she checked the alarm locator panel, she determined it was the one in the activity room. She said it was the Memory Care supervisor who retrieved the resident from the ALF.

On at 11:26 a.m., the Memory Care supervisor said that on [redacted], an employee of the ALF called her and said the resident was outside. The supervisor responded and found the resident in the alcove of the ALF. She said she found a torn screen in the activity room, so she assumed it was the exit route taken by the resident. She said the screen was immediately repaired. She placed one-on-one staff with the resident until 10 p.m. that night. She said that on , she received a call from a staff member, who informed her the resident was returned to the facility by a school resource officer. The supervisor again placed one-on-one staff for the remainder of that shift then instructed the staff to check on the resident every 15 minutes thereafter.

The administrator was present during that interview and said she spoke with the resident's family and asked them to refrain from taking the resident on frequent outings because when they returned him to the facility, his exit-seeking behavior increased. She said following the resident's elopement, it was determined that the resident broke the courtyard gate, which was immediately repaired. She said the residents

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A 025	Continued From page 11 were allowed unrestricted access to the gated courtyard. On at 3:25 p.m., both the ALF and the nearby school were seen. The ALF was located approximately 20 and the school approximately 800 . . from the facility. Class II	A 025		
AN278 SS=D	59A-36.022(3) FAC; 429.07(3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services from facility staff. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health... This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain nursing assessments conducted by a registered nurse (RN) at least monthly for 1 of 1 sampled resident who received	AN278		

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AN278	Continued From page 12 a Limited Nursing Service (LNS) (#7). Findings: Resident #7's record revealed a facility admission date of . A current assessment 1823 form, dated , indicated the resident's diagnoses included . The record contained a health care provider's order, dated , to admit the resident to LNS monitoring for care. On at 2 p.m., the supervisor provided only one resident assessment, which was completed by the supervisor, who was a licensed practical nurse (LPN), and was reviewed by staff D, a registered nurse (RN). The assessment was dated , the day of the survey. On at 11:02 a.m., staff D said she was not told the facility had LNS residents until , which was why assessments were not completed prior to that. She also said the LPN conducted the assessment, and that she only reviewed it remotely, then signed it. Class III	AN278		