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
	AL11965370	A. BUILDING: _____ B. WING _____	04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ALTAMONTE SPRINGS	360 MONTGOMERY ROAD ALTAMONTE SPRINGS, FL 32714

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A 000	Initial Comments Complaint Investigation #2022006074 was conducted on , , and . at Brookdale Altamonte Springs with Limited Nursing Services (LNS) had deficiencies at the time of the visit.	A 000		
A 076 SS=J	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No	A 076		

AHCA Form 3020-0001

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

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A 076	Continued From page 1 =Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , staff trained in , ( ) or a health care provider present in the facility, may withhold (and). (b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by: Based on facility's documentation, personnel record review, and interview the facility failed to honor its ( )	A 076		

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A 076	Continued From page 2 policies and procedures for 1 of 6 sampled residentswho did not have a and ( ) was never performed at all (#5), and the facility's ( ) policy did not explain the facility's implementation of Florida's state laws & rules completely on the , such as procedures to honor a properly executed , procedures to address residents who receive hospice services and procedures to address occurrences in which residents do not have a as required. Findings: Review of a report submitted to the Agency for Health Care Administration (AHCA) dated revealed on at approximately 6:20 AM, resident #5 was found in her apartment on the bathroom floor unresponsive, no , , , open, , , (blue) on her left side by Medication Technician (Med Tech) C. Med Tech C called Caregiver D for help and Emergency Medical Services ( ) was called immediately. First responders arrived about 10 minutes later (about 6:30 AM). Nurse E, who was in charge, was notified via telephone. Resident #5's record review revealed an admission date of . The Health Assessment form 1823 was dated . The resident's diagnoses were , , , and repeated . The resident needed assistance with Activities of Daily Living (ADLs) , and toileting. The resident also needed assistance with self-administration of medications. Resident #5's record revealed she was to receive , resucitation ( ) and did not have a ( ).	A 076		

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A 076	Continued From page 3 On at 10:51 AM, Caregiver F, who has worked at the facility for 3 months, said was and means not to give to the resident if they had a . Caregiver F said she completed the training online three months ago and certification in person last month. Caregiver F stated she was just a caregiver and did not do . She said she would tell the nurse and Med Tech on duty if she found a resident unresponsive. On at 10:53 AM, Med Tech G said she had been working at the facility since , . Med Tech G said that a was a and that you do not give , to the person with a . For a resident without a , you would call and start immediately. Med Tech G confirmed that she had training in-person. She said the training was received via a video and online taken at the facility. On at 12:01PM via telephone, Med Tech C stated she had been working at the facility since mid- , . Med Tech C stated on , she went to resident #5's room at 6:20 AM to get the resident ready for breakfast. Med Tech C stated resident #5 sometimes needed help to get ready in the morning. Med Tech C said she knocked on resident #5's door and said "Hi, how are you? Are you okay?" The resident did not respond. When Med Tech C approached the apartment's bathroom, she observed the bathroom light on and thought the resident was in the bathroom. Resident #5's wheelchair blocked the bathroom doorway. Med Tech C said she found resident #5 lying on the bathroom floor on her left side, facing the toilet with her left	A 076		

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A 076	Continued From page 4 balled up in a fist. Med Tech C asked the resident again if she was okay, but resident #5 did not respond. The resident did not move, and her , were blue. Med Tech C checked the resident's radial ( ), . Med Tech C called Caregiver D immediately on the walkie-talkie for assistance. Med Tech C confirmed that there was no ( ) on the of resident #5's door. Caregiver D arrived in less than a minute to resident #5's room with resident #5's chart and the facility's cordless phone for Med Tech C to call . Med Tech C gave a full description that resident #5 was found unresponsive, no , and , were blue and said to the 911 operator, "I believe she is ." The 911 operator asked Med Tech C if there was anything else to do? Med Tech C answered "No", and the 911 operator instructed Med Tech C not to touch the resident and that she would send and police to the facility. Med Tech C stayed with the resident while Caregiver D went to open the facility's front door for to direct them to resident #5's room. Med Tech C stated that they arrived about a minute or two later from when she called 911. Med Tech C stated she observed put some white pads on resident #5's and heard the medics announce that resident #5 was at the scene. The local law enforcement arrived about 5 minutes after . Med Tech C stated she did not observe any injury or to resident #5. Med Tech staff C confirmed that she did not attempt or do on resident #5, and filed a police report with the police there onsite. Med Tech C confirmed that she only had training online with Relias and , ( ) certification training about a month ago. On at 3:16 PM, the Administrator and Director of Nursing (DON) confirmed that the	A 076		

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A 076	Continued From page 5	A 076		

DON was on vacation during the incident with resident #5. While she was gone, Nurse E was in charge. The Administrator stated Nurse E texted him that resident #5 , , on early morning and was called. The administrator stated Nurse E briefly told him the overnight care staff was doing normal routine checks and the last routine check done by Caregiver D checked on resident #5 at 3 AM. He said Med Tech C went to resident #5's room at 6:20 AM and found the resident lying on the bathroom floor, unresponsive, , blue and no , ... Med Tech C called out on the walkie talkie for Caregiver D to come to the resident's room and call . . 911 was called by Med Tech C and stated that the 911 operator asked her if there was anything else to do; she answered "No", and the 911 operator instructed Med Tech C not to touch anything. . . and police arrived at the facility within minutes. Resident #5's family was called by Nurse E. The Administrator stated he arrived at facility at about 7:45 AM. He stated he assisted with consoling family and spoke with the law enforcement officer who was at the facility. The Administrator stated he completed the Adverse Incident Report to AHCA and had a verbal conversation with both Nurse E and Med Tech C, explaining that should have been done immediately when Med Tech C called 911 no matter what. The Administrator stated that he requested from the local law enforcement agency a copy of the 911 telephone call tape recorded on . . . . . at 6:30 AM. After the Administrator explained the incident on at 6:30 AM regarding to resident #5, he also confirmed that the facility did not follow their policy and the facility's . . policy did not specify or indicate how the facility would honor a in detail specific to the facility's policy. The Administrator stated that the facility's

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A 076	Continued From page 6 expectation was that all staff was to immediately begin . He confirmed that during this incident, staff did not follow the facility's expectation. On at 11:31 AM, Caregiver F said she did not receive additional / training since the event with resident #5 on . On at 11:38 AM, Med Tech G stated during her briefing after reporting to work the next evening, , Nurse E provided a reminder of where the 's were located in the facility, and for those residents who did not have a , was to be initiated. Med Tech G said she signed off on the briefing, but it was not a training. On at 11:45 AM, Med Tech C was asked if she had received training from the Administrator after last week's incident following the of resident #5. Med Tech C answered "No". She said it was not a training, but it was a verbal reminder and discussion with the Administrator and Nurse E on the telephone to always do to all residents who do not have a , and where all the are located in the facility. Review of the facility's policies and procedures, which were last revised on read, "Will honor , physician's orders for life-sustaining treatment, medical orders for life-sustaining treatment, physician's orders for scope of treatment and/or any specific form and process. The does not apply to first aid events such as residents experiencing accidents or life-threatening emergencies not due to natural causes . . . the facility will presume that a resident or his/her legally responsible party has consented to unless there are documented	A 076		

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A 076	Continued From page 7 found in the resident's record." Photographic evidence was obtained. There was no evidence that the facility had provided . . to resident #5, who was to receive , , resuscitation. On at 11:20 AM, Nurse E said that on . . . . . at approximately 6:30 AM, Caregiver D called her from the nurses' station and reported that resident #5 was found on the floor in her room, that her , were blue, and she was to the touch. Nurse E said she asked the caregiver if was performed on the resident and caregiver D's response was that it was not. Nurse E then told caregiver D to do so. Nurse E remained on the phone while caregiver D returned to the resident's room, at which time the paramedics had arrived. Nurse E said she then arrived at the facility at approximately 7 a.m. and saw resident #5 lying on her bathroom floor and facing the toilet. Nurse E said she told both caregiver D and med tech C, who was the first to find the resident, that should have been started immediately because resident #5 did not have a . Nurse E said if a resident had a , a copy could be found on the . . . of their room door, a copy was in their chart, it could be accessed in the electronic charting software, and a copy was kept in an evacuation binder at the front desk. She said a yellow sticker was also placed on the , of the resident's chart. On at 11:45 AM, Caregiver D said she worked a double shift on . . . . . , from 3 PM to 7 AM, and when she arrived at 3 PM, she saw the resident eating popcorn in the lobby. On . . . . . at approximately 3 AM, she "peeked in on" resident #5 and saw her lying in her bed. Then, while doing rounds at approximately 6 AM, she	A 076		

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A 076	Continued From page 8 received a radio call from Med Tech C, who reported that resident #5 was on the floor and was unresponsive. Caregiver D said she went to the resident's room and saw the resident lying on the bathroom floor. Caregiver D said she checked the resident's , , which was not present, and Med Tech C phoned 911 for . . . Caregiver D then ran to the nurses' station to get Nurse E's phone number and to retrieve the resident's chart. She called Nurse E to ask where she could find the resident's medication list. She was returning to the resident's room when she saw . . at the facility's front door. She said she did not receive training on the facility's policy. She said she understood that if a resident did not have a , she was to perform . She said if a resident had a , it would be posted on the of their room door. She said in this case and prior to going to the nurses' station, she did not attempt on resident #5 and did not look on the . . . of the resident's door to see if there was a . On at 12:39 PM, Caregiver B said that on both . . . . . and . . . , resident #5 did not go to the dining room for lunch and dinner, saying that she was not hungry. She did go for breakfast each day. The Caregiver said that on between 6:30 PM and 7 PM, and again at 10 PM, she checked on the resident, and each time found her sleeping. On . . . . . at 11:25 AM, Caregiver B said that she did not receive any follow-up training after the incident involving resident #5. On . . . . . at 11:34 AM, Caregiver A said she did not receive any follow-up training. On at 11:39 AM, Caregiver D also said	A 076		

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A 076	Continued From page 9 she did not receive any follow-up training. Class I	A 076		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to have documented evidence to indicate 6 out of 7 sampled staff received at least one hour of training in the facility's policy and procedures regarding ( ) that included information in Rule 59A-36.009 Florida Adminsitrative Code (A, B, C, D, F & G). Findings: 1. Review of personnel records revealed the following: Caregiver A was hired on . The record contained a facility 1-hour certificate of training,	A 090		

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A 090	Continued From page 10 dated , on . Caregiver B was hired on . The record contained a facility 1-hour certificate, dated . Caregiver C was hired on . The record contained a facility 1-hour certificate, dated . Caregiver D was hired on . The record contained a facility 1-hour certificate, dated . Caregiver F was hired on . The record contained a facility 1-hour certificate, dated . Caregiver G was hired on . The record contained a facility 1-hour certificate, dated . The administrator was named as the instructor on the certificates for caregivers B, C, D, F & G. On at 10:25 AM, Caregiver B said she did not think she received training on the facility's policies and procedures. She said she understood that a meant that the person did not want mechanical life support. She said she was , resuscitation ( ) certified and said a resident's was posted on the of their room door. She said if a resident was unresponsive, she would first call the nurse and if the resident did not have a , she would perform . On at 10:30 AM, Caregiver A said she did receive training on the facility's policies. She understood a meant that she was not	A 090		

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A 090	Continued From page 11 to revive the person. She said were posted on the of the resident's door. She said if a resident was unresponsive and they did not have a , she would call Emergency Medical Services ( ). If a nurse was on duty, she would call them. If a nurse was not there, she would call them on the phone. If she could not reach the nurse, she would call the director of nursing or ask another staff member to help her. When specifically asked by the agency representative whether she would perform on someone who did not have a , she said that she would. On at 11:45 AM, Caregiver D said she did not receive training on the facility's policy. She understood that a meant that should not be performed. She said if a resident was unresponsive and had a , she would call . If the resident did not have a , she would perform . On at 3:15 PM, both the Administrator and the Director of Nuring (DON) said newly hired staff received training from an online education software, which involved watching a video. The Administrator said that although he signed the facility certificates as the instructor, he did not provide the training and said he signed them only because he understood from a previous survey that the training had to be given by someone who was Core trained. The administrator then said the online video did include facility specific training and he provided certificates for all the sampled staff that were generated from the software. However, the certificates did not contain an agenda to prove the staff received at least one hour of training on the facility's policy. An opportunity was given to provide an agenda but he was unable to.	A 090		

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A 090	Continued From page 12 2. On at 10:51 AM, Caregiver F, who has worked at the facility for 3 months, said was and means not to give to the resident if they had a . Caregiver F said she completed the training online three months ago and certification in person last month. Caregiver F stated she was just a Caregiver and would tell the nurse and Medication Technician (Med Tech) on duty. On at 11:31 AM, Caregiver F said she only received training when she was hired 3 months ago. 3. On at 10:53 AM, Med Tech G said she worked at the facility since , . Med Tech G said that a was a and that you do not give to the person with a and for a person without a ; you would call 911 and began immediately. Med Tech G confirmed that she has both training in person. She stated the training was received via a video and online taken at the facility. On at 11:38 AM, Med Tech G stated during her briefing after reporting to work the next evening on , Nurse E provided a reminder of where the were located in the facility and for those who do not have a , must be done. Med Tech G said she signed off on the briefing, but it was not a training. 4. On at 3:16 PM, the Administrator and Director of Nursing (DON) confirmed that the DON was on vacation during the incident with resident #5. While she was gone, Nurse E was in charge. The Administrator stated Nurse E texted him that resident #5 , , on early morning and was called. The administrator stated Nurse E briefly told him that	A 090		

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A 090	Continued From page 13 the overnight care staff was doing normal routine checks and the last routine check done by Caregiver D checked on resident #5 at 3 AM. He explained Med Tech C went to resident #5's room at 6:20 AM and found resident #5 lying on the bathroom floor, unresponsive, , blue and no , . . . Med Tech C called on the walkie talkie for Caregiver D to come to the room and call 911 for . . Med Tech C stated that the 911 operator asked her if there was anything else to do; Med Tech C answered "No", and the 911 operator instructed Med Tech C not to touch anything. . . and police arrived at the facility within minutes. Resident #5's family was called by Nurse E. The Administrator stated that he arrived at facility at about 7:45 AM on . The Administrator stated he assisted with consoling family and spoke with the law enforcement officer who was at the facility. The Administrator stated he completed the Adverse Incident Report to the Agency for health Care Adminsitration and had a verbal conversation with both Nurse E and Med Tech C, explaining that . should have been done immediately when Med Tech C called 911. The Administrator stated that he requested from local law enforcement a copy of the 911 telephone call tape recorded on . at 6:30 AM. After the Administrator explained the incident on . . . . . at 6:30 AM regarding to resident #5, he also confirmed that the facility did not follow their . . policy and the facility's . . policy did not specify or indicate how the facility would honor a . . in detail specific to the facility's . policy. The Administrator stated that the facility's . expectations was that all staff was to immediately begin , and that the staff during this incident did not follow the facility's . expectation. Class III	A 090		

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
	AL11965370	A. BUILDING: _____ B. WING _____	04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ALTAMONTE SPRINGS	**360 MONTGOMERY ROAD ALTAMONTE SPRINGS, FL 32714**

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