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
	AL11965390	A. BUILDING: _____ B. WING _____	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST MELBOURNE	7199 GREENBORO DR WEST MELBOURNE, FL 32904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Complaint Investigation #2022006495 was conducted on [redacted] Brookdale West Melbourne had a deficiency at the time of survey.	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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.	A 025		

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to 2 of 3 sampled residents who eloped from the facility (#1 & #2), and 1of 3 residents who has exit seeking behaviors (#3). Findings: 1. Review of resident #1's record revealed documentation that indicated the resident eloped from the facility on [redacted]. Review of the facility's resident elopement policies and procedures revealed they were	A 025		

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A 025	Continued From page 2 revised in . . . . . The policies indicated the definition for elopement in 's and . . . . . Unit is any incident where a resident leaves the secured memory care area of the community or the secured courtyard, unescorted with or without injury. Review of resident #1's record revealed a facility admission date of . . . . . The diagnoses listed were , , history of . . . and . . . . . His record contained an 1823 Health Assessment Form (1823) dated . . . . . Review of 1823 revealed the resident was an elopement risk. Further review of 1823 revealed the resident required assistance with bathing, , grooming, toileting and transferring. Supervision was quired for eating. The 1823 revealed that the resident's needs can be met in assisted living facility. Resident #1's record contained facility notes of exit-seeking and elopement attempts as follows: at 3:06 AM, the resident was exit-seeking. at 5:23 AM, the resident was exit-seeking. at 3:38 AM, the resident was exit-seeking. at 11:49 PM, the resident was exit-seeking. at 2:33 PM, the resident was exit-seeking. at 2:32 AM, the resident was exit-seeking. at 5:09 AM, the resident was exit-seeking. at 10:17 AM, the resident attempted to get out of the backdoor on C hall. at 8:03 PM, the resident was	A 025		

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A 025	Continued From page 3 exit-seeking. at 1:19 PM, the resident set off exit door on B hall, attempting to walk out the door. at 10:50 PM, the resident was standing outside of the C hall exit door on the sidewalk. at 11:32 AM, the resident left the facility with another resident out of the C hall door. Staff responded to the door alarm. A nurse's note described the area as unsafe due to a hole by the C hall exit. The note indicated 2 police officers had to escort resident into facility. at 10:59 PM, the resident was exit-seeking. A note indicated he was trying to find his wife. at 5:51 PM, the resident was exit-seeking. at 2:15 PM, the resident was seen outside the C hall door by the gate, attempting to get out to the road. at 9:47 AM, staff responded to an alarm on the C hall. When staff arrived, the resident was outside trying to open the gate. 2. Review of resident #2's record revealed documentation that indicated the resident eloped from the facility on . Resident #2's record revealed a facility admission date of . The record contained an 1823, dated . The 1823 listed diagnoses of , of the , , , , , and atherosclerotic . The 1823 revealed the resident was an elopement risk. Resident #2's record contained another 1823, dated , indicating the resident was not an elopement risk. The 1823 revealed the resident was receiving hospice care and was and forgetful. The 1823 revealed that	A 025		

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A 025	Continued From page 4 the resident required supervision with ambulation, eating, and transferring. The 1823 revealed the resident's needs can be met in assisted living facility. Review of resident's record contained facility notes of exit-seeking and elopement attempts as follows: . . . . . at 12:13 AM, the resident was exit-seeking and hitting doors. . . . . . at 5:04 PM, the resident continued to exit-seek and press on the doors, setting off the door alarms. The note also indicated the resident did not sleep all night and a resident caregiver had to stay with her all night. at 4:55 AM, the resident had a sitter with her all night to keep her from hitting doors which made the door alarms go off. . . . . . at 4:43 AM, the resident pushed on exit doors and made the alarms go off. . . . . . at 11:16 PM, the resident was exit-seeking. . . . . . at 2:24 AM, the resident was exit-seeking. . . . . . at 4:52 AM, the resident was exit-seeking. . . . . . at 10:02 AM, the resident attempted to elope from the facility via the kitchen and employee lounge door. at 5:45 AM, the resident was on C hall attempting to open the kitchen door. at 6:22 PM, the resident was observed outside of the D hall door. at 5:01 PM, the resident pushed doors and hit windows. at 8:47 AM, the resident continued to exit-seek. at 2:45 AM, the resident hit the D hall door making the alarm go off. at 2:57 PM, the resident attempted to	A 025		

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A 025	Continued From page 5 set off the emergency door on the D hall and front lobby. . . . . . at 5:45 AM, the resident tried to set off the front door alarm. . . . . . at 3 AM, the resident tried to get out of the facility. . . . . . at 4:05 AM, the resident was exit-seeking. On at 11:30 AM, staff A stated she worked on . . . . . at the time of elopement incidents. She could not recall if resident #1 exited through D or C hall exit. She recalled hearing the alarm and then the alarm stopped. She said at that same time, resident #2 attempted to exit the D hall door. She said it was right after dinner and she heard the alarm. She said when resident #2 went out of the door, she escorted her . . . inside the facility. Staff A stated she was easily redirected into the facility. Staff A said residents #1 and #2 try to get out "a lot". When she sees the residents going toward the exit doors, she tries to redirect them. She said she did see a Velcro stop sign on the exit doors the day after the elopement incidents, but the residents pulled them off. On at 11:40 AM, staff B said she could not recall residents getting out of the building. If she heard an alarm, she would immediately go to the panel to see which door. Staff B said resident #2 is always around the doors, but she does not go out. She said resident #1 will push on the doors. Staff B said she had elopement training and participated in elopement drills. Staff B said there is enough staff on each shift to meet the needs of the residents. She said there were stop signs on the exit doors, but the residents took them off.	A 025		

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A 025	Continued From page 6 On [redacted] at 12:10 PM, staff C she said on [redacted] she heard from other staff that resident #2 exited the building through the side door. She did not recall any other residents eloping from the building. Staff C said she was not working on that hall that night. She said resident #2 would try to escape all the time. She said resident #2 would push the doors but not go out. She said she did notice stop signs on the exit doors after the incident. On6/28/2022 at 3:40 PM, staff D stated all the residents wear an identification bracelet on their [redacted] or ankle. Staff D said she encourages all residents to attend activities. She further stated resident #1 will go to activities but he likes to walk around. Staff D said she was not present for the elopement of resident #1 and #2 on [redacted] but she was aware of it. Staff D confirmed during the interview she had to escort resident #1 and #2 [redacted] into the building on [redacted]. Two police officers assisted with resident #1 as documented in the facility notes. She also said the area was unsafe due to a hole by the C hall door. On [redacted] at 3:48 PM, a tour with staff D was conducted of the C hall exit door and outside area. During the tour, staff D confirmed a Velcro sign was not present on the exit door. The C hall door exited to a fenced area behind the building. 3. Resident #3's record revealed a facility admission date of [redacted]. The 1823 documented the resident's diagnoses as [redacted], major [redacted] and [redacted] with behavioral disturbances. The record contained an 1823, dated [redacted], which revealed the resident was an elopement risk. The 1823	A 025		

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A 025	Continued From page 7 revealed the resident was independent with all activities of daily living except eating for which she required supervision. The 1823 revealed that the resident's needs can be met in assisted living facility. Review of resident's record contained facility notes of exit-seeking and elopement attempts as follows: at 12:45 PM, the resident was exit-seeking and grabbed at another resident who was attempting to leave with family. . . . . . at 10:03 AM, the resident set off the alarm on the A hall. . . . . . at 2:49 PM, the resident attempted to elope. . . . . . at 9:30 AM, the resident attempted to exit the facility with another resident. Staff responded to the alarm and observed both residents exited the facility. . . . . . at 5:50 AM, the resident was exit-seeking. On at 4 PM, the Director of Resident Care and the Administrator confirmed resident #1 and 2 exited the secured memory care unit unescorted on . . . . . Class II	A 025		