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
	AL11965818	A. BUILDING: _____ B. WING _____	06/08/2022

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 Unannounced Complaint Investigations #2022005758 and #2022005683 were conducted from to 21/2022 and on , 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	A 025		

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A 025	Continued From page 1 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. This Statute or Rule is not met as evidenced by: Based on 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 9 sampled residents who eloped from the facility (#5 & #10). Findings: 1. Review of resident #5's record revealed a facility admission date of . . . . . An 1823, dated , indicated the resident's diagnoses included . . . . . , ... with , ... type 2 with	A 025		

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A 025	Continued From page 2 Poly . . . , . . . , . . . atrophy, ... , ... , . . . , . . . , . . . , ... low . . . , . . . of . . . , and . . . of . . . . The form indicated the resident was independent with all activities of daily living (ADLs) and mobility, and that she was not an elopement risk. The record contained a health care provider's order, dated . . . , for . . . 40 milligrams (mg) by . . . daily. A facility note, dated . . . . . at 2:06 p.m., indicated the resident complained of , . . . all over her body and her left pinky . . . was throbbing. The resident asked to be sent to the hospital. The record did not contain documentation to indicate the facility contacted a health care provider regarding the resident's complaint of , . . . A facility note, dated . . . . . at 5:28 p.m., indicated that non-emergency ambulance transport arrived at the facility to transport the resident to the hospital but, the resident refused and stated her family member would take her instead. A facility note, dated . . . . . at 1:29 p.m., indicated the resident left the facility without signing out. The resident walked across the street to a place of business and refused to leave their premises. A facility nurse and a caregiver walked to the business and tried to get the resident to return to the facility however, the resident refused to leave, became loud, and walked into the business's employee offices. 911 was called and the resident was transported to a hospital. A facility note, dated . . . . . at 3:01 p.m., indicated the facility received a report from the	A 025		

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A 025	Continued From page 3 hospital that the resident would be returning to the facility and that the resident complained of , while at the hospital. A facility note, dated at 11:26 a.m., indicated the resident was seen shaking and running through the halls of the facility. The facility contacted the resident's power of attorney (POA) several times however, the POA the facility and declined services that were offered to keep the resident safe. A facility note, dated at 1:20 p.m., indicated that 911 was called due to the resident shaking and running through the halls. The responding emergency medical personnel were able to reach another family member, who indicated the resident had major , , issues. The resident was transported to a hospital. A facility note, dated at 11:08 a.m., indicated the resident returned to the facility from the hospital on the previous night. The facility sent a discharge notice to the resident's POA via overnight mail on the previous day. A facility note, dated , indicated that a Doctor of Podiatry Medicine ordered , 500 mg by every six hours for 7 days for left and , 500 mg by twice a day for 7 days. The resident's record did not contain documentation to indicate a health care provider was contacted about the resident's earlier complaints of , prior to this note. A facility note, dated at 9:53 AM, indicated the resident tried to leave the facility several times during the night. Facility staff provided her with one-on-one supervision.	A 025		

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A 025	Continued From page 4 A facility note, dated at 3:36 p.m., indicated the resident continued trying to leave the facility and staff redirection was provided. Review of the facility's discharge log revealed documentation that indicated the resident was discharged from the facility on due to behaviors. During an interview with med tech W, on at 2:06 PM, she said that on at approximately 9 AM she gave resident #5 her morning medications and it was at that time that the resident said her hurt. The med tech said she looked at the resident's but, did not see anything so she told the resident that she would report the resident's complaint to a nurse. The med tech said she reported the resident's complaint to lead med tech C, who said she would tell the wellness director B. Med tech W said that later that morning between approximately 11 AM and 11:30 AM, she saw the resident in her room and reminded the resident that it was time to go down for lunch and the resident responded "okay". The med tech said the resident did not say anything at that time about her , so the med tech assumed a nurse addressed the complaint. The med tech said she saw the resident in the dining room during lunch. The med tech said the resident did not say anything to her on that morning nor at any other time that would indicate the resident was going to leave the facility. Med tech W said resident #5 was oftentimes and the med tech had to calm the resident down. During an interview with med tech L on at 2:28 PM, she said regarding resident #5, "most of the days the resident came out of her room and	A 025		

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A 025	Continued From page 5 told both residents and staff that her [illegible] hurt but at the time she did not have [illegible] meds". The med tech then said, "she spoke gibberish, you don't understand what she's saying; sometimes you had to tell her to slow down so you could hear what she's saying". The med tech said she reported to wellness director B when the resident complained of [illegible] and that the resident asked for [illegible] medicine. The med tech could not remember the last time she saw the resident on [illegible] and said the resident was "[illegible] and always shaking". During an interview with med tech E on [illegible] at 3:05 PM, she said that since resident #5's admission to the facility, the resident had trouble sleeping and [illegible] throughout the facility during the night then said, "to the point where we had to follow her around". The med tech said the resident was oftentimes very nervous and preoccupied with the time of breakfast, was fearful that no one would come get her for breakfast and would oftentimes sit in the dining room beginning several hours before breakfast was due to be served. The med tech said the resident did, at times, walk towards exit doors but, when she saw staff, she turned around. During an interview with med tech X on [illegible] at 3:30 PM, she said resident #5 was [illegible] at times and [illegible] around the facility during the 3 PM to 11 PM shift. The med tech said that when the resident [illegible], she did not appear to have a purpose and oftentimes could not find her room. The med tech said that when the resident first moved into the facility, she complained of [illegible], and [illegible]. The med tech said the resident did not initially have [illegible] medications prescribed, which "was a bone of contention with both the resident and her family member".	A 025		

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A 025	Continued From page 6 2. Review of resident #10's record revealed a facility admission date of [redacted]. An 1823, dated [redacted], indicated the resident had [redacted] and that he was not an elopement risk. A facility note, dated [redacted] at 2:26 PM, indicated the resident eloped from the facility. The resident was last seen at approximately 7:30 AM by staff at breakfast. When facility staff went to remind the resident of lunch at approximately 11:30 AM, he was not seen in either his own room or in his friend's room. That friend said that this resident told her that he was going to a store to get snacks and would be [redacted]. The friend was unable to provide a time however, she said it was some time after breakfast that morning. Facility staff searched the facility, and the administrator contacted the resident's family member, who said the resident was not with family. Local law enforcement was notified and were able to locate the resident. The resident's family member responded to that location then returned the resident to the facility at approximately 1:15 PM. The resident told his family that he went to the store to purchase medication for his [redacted] and [redacted], however, he got lost on his way [redacted] to the facility. A health care provider was notified, and the resident's family member stayed at the facility until a private sitter could arrive. The facility's plan was to have a private sitter with the resident from 7 AM to 7 PM until further notice. A facility note, dated [redacted] at 10:12 AM, indicated the resident's family moved the resident out of the facility. During an interview with med tech W, on [redacted] at 2:06 PM, she said that on [redacted] she last saw resident #10 in his room at approximately 9 AM.	A 025		

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A 025	Continued From page 7 The med tech said that when she returned to remind the resident to go to lunch at approximately 11:10 AM, the resident was not there, which she said was unusual for him. The med tech then went across the hall to see if the resident was in his friend's room but, the resident was not. The friend told the med tech that this resident said he was going to walk around. The med tech checked the resident sign-out book and found that the resident had not signed out of the facility. The med tech then notified the administrator. The med tech said a search was conducted both inside and outside of the facility. The med tech said the resident was normally very quiet and when not visiting with his friend across the hall, he stayed to himself. The med tech said she had only ever seen the resident go outside as far as the porch. The med tech said that on the morning of the elopement, the resident did not say anything to her about having , , wanting , medicine, or wanting to go to the store. During an interview with med tech L on at 2:28 PM, she said resident #10 usually came down for meals then returned to his room. The med tech said she never heard the resident say he was going to leave the facility and said she had to provide meal and other routine reminders to him when he first arrived at the facility but, after a couple of days, she no longer had to. During an interview with med tech E on at 3:05 PM, she said that resident #10 usually slept all night and only once did he get up in the middle of the night and thought it was morning. The med tech said she reminded him of the time, and he returned to bed. During an interview with med tech X on at 3:30 PM, she said that when resident #10 was not	A 025		

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A 025	Continued From page 8 visiting with his friend across the hall, he mostly stayed in his room. The med tech said she never saw the resident . . . or exit-seek. class II	A 025		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 . . — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times	A 079		

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A 079	Continued From page 9 when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or	A 079		

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A 079	Continued From page 10	A 079		

manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require

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A 079	Continued From page 11 additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility placed the resident community (66 residents) at-risk by failing to maintain a work schedule reflective of work patterns and failed to ensure the facility always maintained a staff member in the building with	A 079		

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A 079	Continued From page 12 . . . . . (.) and First Aid. Findings: On . . . . . at 9:03 AM, copies of the current work schedule for the facility were requested. On . . . . . at 12:15 PM, the administrator stated she did not know why the word "injection" was listed as a staff duty. The administrator stated the facility is very short staffed and have been using an outside agency to provide staff. The administrator was not sure if the outside agency staff had completed background screenings, or training in first aid or . . On . . . . . at 12:20 PM, the Administrator and Wellness Director were asked what the word "injection" meant on the schedule. The Wellness Director looked at the schedule stated it reflected the hours worked by outside agency staff, it is not the actual work schedule. The schedule did not reflect the hours worked by outside agency staff, only those employed by the facility staff. Review of the work schedule for the current work week, ... to . . . . . , reflected on the overnight shift, 11 PM to 7 AM, the following: . . . . . , Medication Technicians (Med Tech) I, E and F were scheduled to work . . . . . , Med Tech I, E and F were scheduled to work . . . . . , Resident Aide H and Med Tech E and F were scheduled to work . . . . . , Resident Aide H and Med Tech E were scheduled to work . . . . . , Med Tech I and Resident Aide H were scheduled to work.	A 079		

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A 079	Continued From page 13 On , employee personnel review found the following results: Med Tech E did not have documented training in first aid, Med Tech F did not have training in first aid, Med Tech I did not have training in first aid, and Resident Aide H did not have training in first aid. On at 7:50 AM, Resident Aide H stated her date of hire was . She stated she was not working in the facility but still going through training and should not be on the work schedule. On at 8:20 AM, Med Tech F stated his date of hire was . He stated the facility does not have enough staff at night, and that many times only two staff work in the entire building. On at 8:30 AM, Med Tech E stated her date of hire was . She stated on most shifts, the facility has two staff on-duty for the entire building. Class III	A 079		