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
	AL11965474	A. BUILDING: _____ B. WING _____	12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEKIWA SPRINGS	203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703

(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 #2022018441 was conducted on [redacted], [redacted] and [redacted]. Brookdale Wekiwa Springs had deficiencies at the time of the survey.	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 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; [redacted], 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- [redacted] 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.	A 030		

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A 030	Continued From page 1 (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; 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.	A 030		

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A 030	Continued From page 2 429.28 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 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.	A 030		

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A 030	Continued From page 3 (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 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	A 030		

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A 030	Continued From page 4	A 030		

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 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

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A 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [redacted] Hotline operated by the Department of Children and Families, and [redacted], Rights Florida. 429.27 Property and personal affairs of 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 [redacted] or [redacted] under state law, 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 honor resident's rights by failing to perform [redacted] ([redacted]) on 1 of 4 sampled residents who was found to be unresponsive and who did not have a [redacted] ([redacted]) (#6). Findings: Resident #6's record revealed a facility admission date of [redacted]. An 1823 health assessment	A 030		

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A 030	Continued From page 6 form, dated . . . . . , indicated the resident had a diagnosis of . The resident lived in the facility's memory care unit. The resident's record did not contain a . The resident's sheet indicated "full code", which means to provide , , when needed. The resident's information sheet, dated , indicated she did not have advanced directives, such as a living will and . . A facility note, dated . . . at 7:51 AM, indicated the resident expired on the night shift. The note did not contain any other documentation, including any details about the circumstances surrounding her . . . . A release of . . . . . resident form, dated . . . . . at 10:33 AM, indicated the resident's body was released to a funeral home. A facility incident report indicated that on . . . at 7 AM, the administrator received a call from caregiver A stating the resident , ... , and that paramedics came to the facility to perform . and that caregiver A had called them. The administrator asked the caregiver if the resident was a full code and caregiver A said "yes". The administrator asked her why the staff did not perform . and caregiver A replied, "They just didn't." She said she was listening to the 911 operator and "preparing" the resident for . . The facility's . policy, last revised on . . . . . , read, "If a resident goes into and/or , ... , ... , it is our policy to call 911 and follow the instructions of the operator. An associate certified in . will perform . . An associate not certified in . will perform -only . if instructed by the 911 operator while waiting for a certified associate or	A 030		

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A 030	Continued From page 7 emergency first responders. In the event a resident is found to have no , and/or is not breathing, an associate should: Call 911 immediately, Verify status of the resident, and notify the 911 operator of the resident's current known status. will not be initiated if a order is identified. If the status is not quickly determined by a bracelet or other readily identifiable information, or if you are unable to interpret the per state regulation, then: if certified - initiate and follow any other instructions given by the 911 operator. If not certified - notify the 911 operator that you are not certified and follow the directions of the 911 operator until a certified associate arrives or the emergency first responders arrive. The occurrence and all actions taken must be properly documented in the resident's record. Included in the documentation must be the date and time the resident was found, the time the emergency first responders were called, the time the healthcare provider was called, and the time the resident's legally responsible party/family was notified." The facility's policy, last revised , indicated that "Brookdale will presume that a resident or the legally responsible party has consented to unless there is a documented in the resident's medical record . . . A copy of the resident's should be maintained in the resident's medical record in a prominent location . . . Associates should receive training on as required per state regulation." On at 11:08 AM, caregiver A said that on at 6:50 AM caregiver B called her cell phone and said resident #6 "is gone". When caregiver A went to the resident's room, the resident's "body was ; my mistake I made	A 030		

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A 030	Continued From page 8 was I thought that when you see the person has been gone for a while, you do not have to do ; she'd been gone a while." Caregiver A is not a nurse, not a physician, and not qualified to make this determination. While in the resident's room, caregiver A said she first called the director of nursing (DON) but she did not know the DON was on vacation and the DON did not answer her phone. She then called nurse D, who instructed her to call the family, call 911 and do . Caregiver A told the nurse "She's already been gone a while" and the nurse responded "I know, but you still have to do ." Caregiver A said she did not see a on the of the resident's door, so she went to the nurses' station on the second floor of the assisted living side to look in the resident's chart and verify there was not a . When she saw there was not one, she called 911 and when she told the operator that the resident had been gone a while, the operator told her still had to be performed. Caregiver A then called caregiver B and asked if she was certified. Caregiver A responded "yes" but that she was not going to put her on the resident's . The 911 operator told caregiver A she would call caregiver A on her cell phone to allow her time to return to the resident's room. When caregiver A arrived to the resident's room, neither caregiver B nor caregiver C were present. The 911 operator called caregiver A and instructed her to place the resident on a flat surface. Caregiver A called caregiver B to return to the resident's room. They then placed the resident on the floor and caregiver B left the room and returned with an ( ). The 911 operator instructed caregiver A on how to perform , but paramedics arrived before she could start. Caregiver A said she first determined the resident was already	A 030		

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A 030	Continued From page 9 because "she was not breathing and her was open; her were just staring off; I put my under her ; I put my on her and she was not breathing". She said for those residents with a , a copy of it was placed on the of their room door. She said there was also a book with a copy of everyone's kept in the memory care unit but in this instance, she forgot about the existence of the book before she went to look in the resident's chart. When asked if she received training on the facility's policies related to , she replied "I don't remember if training was given that if a resident was already gone what steps would be taken" and that she only remembered taking a class. She said following the incident, the administrator told her that she should have done . She said otherwise, nothing else occurred to prevent a similar incident, such as additional training. She said that after the incident she texted the administrator and said a refresher course needed to be given, but she never heard from the administrator. "An automated external defibrillator ( ) is a medical device designed to analyze the rhythm and deliver an electric to victims of to restore the rhythm to normal." (retrieved www.osha.gov/). On at 11:27 AM, a request was made of the administrator to provide additional documentation from the resident's record that described the occurrence in more detail. She said that besides the note written on at 7:51 AM, there wasn't any additional documentation. She provided an email that she sent on at 9:52 PM to corporate staff regarding the incident. It read, "Today @ 7am	A 030		

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A 030	Continued From page 10 [caregiver A's name] called me and stated [resident #6's name] has , , she stated that paramedics came to do after she had called them. I asked [caregiver A's name] if she was a full code and she stated yes. I then asked why they [staff] did not start and she stated they just didn't, that she was listening to 911 and was "preparing" resident for . I spoke to the sheriff that arrived and let him know that we would arrange calling family & the funeral home. A funeral home arrived around 10 am this morning to take [resident #6's name]. [Caregiver B's name] was another med tech (medication technician) working overnight with (caregiver A). @ 7:25pm [Caregiver A's name] . . . text me a lengthy text below: "I think that (sic) should be a refreshing class on training and what should be done in the means of an emergency because I was upstairs on the phone with 911 and called [Caregiver B's name] on my cell phone and asked her if she was certified and she said yes but she wasn't doing it on the resident so then I have to have the lady call me . . . on my cell phone go to Memory Care and try to do myself and then [Caregiver C's name] was refusing to leave (another resident) and his wheelchair in the hallway to go let the paramedics and I can't do everything on my own that is why she didn't get done sooner I was upstairs doing my rounds in my medicines and both of them were in memory care so. [Caregiver C's name] was also working and I left a voicemail for her. I called [Caregiver B's name] to find out her statement but she did not answer and I left a voicemail . @ 3:13pm today I called [Caregiver A's name]: [Caregiver A's name] stated that @ 6:50am this morning she was taking trash out and [Caregiver B's name] called her and told her the resident was and had , , . [Caregiver A's name] went in to see the resident. I asked	A 030		

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A 030	Continued From page 11 [Caregiver A's name] if her or [Caregiver B's name] checked for a and she said NO. I then asked when is the last time she was rounded on and [Caregiver A's name] said that she believed [Caregiver B & C's names] rounded on her around 5am. [Caregiver A's name] stated that she told [Caregiver B's name] to start so that she can go upstairs to call 911 and [Caregiver B's name] told her she was not going to do . Then [Caregiver A's name] was downstairs with the resident and [Caregiver B's name] on the phone with paramedics and they told her to move the resident to the floor to prepare for so [Caregiver B & A's names] did so but again did not check for or start . [Caregivers A, B & C's names] all left this morning right after this happened as the police called me upset that they just left and did not give a statement." (End of email) On at 11:38 AM, caregiver B said that she provided incontenent care to resident #6 on between 1:30-3:00 AM and "all was fine". She entered the resident's room again at 6:15 AM and found the resident's " were staring off so I yelled her name". She then called caregiver A on her phone. Her next involvement was when she assisted caregiver A with placing the resident on the floor and when she retrieved the automated external defibrillator ( ), but before it could be used the paramedics arrived. She said she was certified in . She said she did not receive training on the facility's policies and knew only to look on the of a resident's door for a copy of a , which she said resident #6 did not have on her door. When asked why she did not start she said, "I didn't know if she had a ; I started panicking". She said the administrator left her a voice mail after the incident, but she had not yet	A 030		

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A 030	Continued From page 12 returned the call. On at 1:27 PM, nurse D said that on the morning of caregiver A called her and asked if resident #6 had a because the resident was not breathing and was unresponsive. Caregiver A said there was not a on the of the resident's door. Nurse D replied that she did not think the resident had a and told caregiver A to go check the resident's chart to be sure. She then told the caregiver that if there was not one, start , call 911, then call the administrator. The nurse said she "believed" she received training on the facility's policy and "most likely" on the policy. She said a copy of a resident's was in the chart, on the of the room door and in the electronic chart that could be accessed by only nurses and medication technicians. On at 3:10 PM, the administrator said the facility's corrective action to prevent a similar occurrence was that she educated caregiver A over the phone on the process for checking for a , , starting and checking the room door for a . She said she instructed the nurses to remind the caregivers of emergency procedures for example, with ., not leaving a resident alone, checking a , and conducting their rounds. She said that on at 7 AM she received a call from caregiver A who said the resident "looked like that way for a while" and that she called 911, who told her to prepare the resident for by putting her on the floor. She said that a few months prior the facility began placing on the of resident room doors, but the policy had not yet been updated to reflect the new process. She said the facility's policy was that if a resident did not have a ,	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965474	A. BUILDING: _____ B. WING _____	12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 030	Continued From page 13 the staff were required to perform . She said she previously left a message for caregiver B to call her, but had not received a call . On at 2:10 PM, the DON said the staff received "the extensive 1-hr training on on Relias (a web based training module)" and that she "touched bases with them on the policy itself". She did not think the facility had a separate policy on performing . She said all staff were required to be certified in . She said if a resident did not have a , staff were required to immediately start and call another staff members over the radio to call 911. On at 8:29 AM, caregiver C said that on the morning of , she heard the resident humming loudly but did not think it unusual since the resident often sang and talked. She "peeked" in the resident's room, saw her lying in her bed, and she was no longer humming. At approximately 6:00 AM, caregiver B called her to the resident's room and said "I think she's ". Caregiver C touched the resident's forehead and and both felt like the temperature in the room, neither nor hot. She said caregivers A and B took over so she left the room and continued her duties. She said she did receive training on the facility's policies and that she was certified in . She said the only place she knew where to find a copy of a resident's was in a book located in the dining room of memory care. She said the administrator did not call her prior to or during her shift on to speak with her. A review of the staffing schedule revealed that despite the facility having not yet conducted a full investigation into the incident and not yet implementing additional corrective actions and	A 030		

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A 030	Continued From page 14 trainings to prevent similar occurrences, caregivers A, B and C were permitted to work on the night following the incident, ... 11 PM-7 AM, and both staff A and staff C were scheduled to work on ... ... from 11 PM- 7 AM. Documentation in caregiver A's personnel record indicated she last received training on the . and . policies on .. . . and ... . Caregiver B last received training on the and . policies on . . .. Caregiver C last received training on the and . policies on .. .. The Sheriffs' officer's report indicated "On . . . . . , I responded to Brookdale Wekiwa Springs . . . in reference to a . . . investigation. My investigation revealed: Upon arrival, I made contact with Brookdale staff members, who advised the facility is assisted living with hospice care. I was advised at approximately 0645 hrs (6:45 AM), the staff went to check on (resident #6s) residence, who was on hospice but was recently taken off. When they entered the room, they noticed she was . . . to the touch and not breathing. Medical staff entered the room and notified Orange County Fire rescue. Upon the arrival of Orange County Fire rescue, they pronounced [resident #6's name] . . . at 0658 hours (6:58 AM). I was advised by the staff they would be working the . . . . as a Hospice and completing all the necessary arrangements for [resident #6's name] (. . . . notifications, doctor signature, and funeral arrangements). I made contact with Medical Examiner's office and was advised, due to the facility completing all the necessary arrangements they would not be completing a report. I further observed [resident #6's name] to have rigor set in and to be showing obvious signs of . [Resident #6's name] was	A 030		

Agency for Health Care Administration

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A 030	Continued From page 15 turned over to [funeral home name]." Class I	A 030		