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 _____	R 06/08/2023

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 A revisit to a complaint investigation #2022017286 was conducted at Brookdale Lake Mary on . The facility had an uncorrected deficiency at the time of the 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 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 resident diets in accordance with Rule	{A 025}		

AHCA Form 3020-0001

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

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{A 025}	Continued From page 1 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: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews, the facility failed to provide adequate supervision and care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for . . and injuries for 1 of 6 sampled residents (#2) and by not giving 1 of 6 sampled residents their medications as prescribed (#7). Findings: 1. Review of resident #2's record revealed a facility admission date of . A 1823	{A 025}		

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{A 025}	Continued From page 2 health assessment form indicated his medical history included right 's , and risk. He required assistance with bathing, , toileting, ambulation and transferring. A facility risk evaluation scored him as level 3 based on the following identified risk factors: a with injury in the last 12 months, problems ambulating or transferring, appeared unsteady when ambulating, taking , and benzodiazepine medications, 's , and a history of any decline. A personal service plan interventions were to consider a request for further evaluation by a primary care provider (PCP) regarding changes and observations. , include labs and medication review. Consider involvement of physical and occupational therapies ( ) ( ). Encourage program participation as a means to increase observation. Encourage use of a low bed. On at 5:19 pm staff reported that he required with transferring. He had an order for and to start the next day. On at 7:38 pm he receives for transfer and gait training. On at 8:31 pm he slid from his wheelchair. No injuries. On at 2:53 pm he was observed on the floor with his against the recliner. He was not able to explain what happened. No apparent injuries.	{A 025}		

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{A 025}	Continued From page 3 On . . . . . at 4:49 pm he was observed on the floor in his apartment in a sitting position. No injuries. On . . . . . at 5:47 pm he had a earlier and was not able to explain what happened. He was sitting in his recliner. No injuries. On . . . . . at 2:49 pm he was found on the floor. He said he did not but rather he slid from his wheelchair. No apparent injuries. On . . . . . at 2:09 pm he was found on the floor next to his bed. No apparent injuries. On at 8:28 pm he was found on the floor next to his bed. No apparent injuries. On . . . . . at 5:17 pm he was found on the floor close to the toilet, his was . . . . Paramedics were called and he was taken to a hospital. On he had a and was sent to a hospital at around 12 am last night. On . . . . . at 6:20 pm he returned from the hospital. On at 7:40 pm he had an unwitnessed . . He was observed on the floor by care staff. No apparent injuries. The facility's management policy read, in part, a post . evaluation is completed after a resident , individualized interventions are considered, and the evaluation is a part of the resident's record. The facility did not follow its policy as it did not	{A 025}		

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{A 025}	Continued From page 4 complete a post evaluation after each of the resident's . On at 5 pm, the director of nursing (DON) confirmed the findings and was unable to provide additional documentation. 2. Review of resident #7's record revealed a facility admission date of . An 1823 indicated his medical history included . His medications included 40 milligrams (mg) daily for ( ) without and Chlordiazepoxide (Librium) 5 mg three times a day for Achalasia of (Achalasia occurs when in the become damaged. As a result, the becomes paralyzed and dilated over time and eventually loses the ability to squeeze food down into the . Food then collects in the , sometimes fermenting and washing up into the , which can taste bitter. Mayoclinic.org) On a health care provider ordered that nursing administer his medications. Review of his medication observation record (MOR) revealed he was not given both the and Chlordiazepoxide after . There was no doctor's order to stop them and no documentation on either the MOR or in his record to indicate why they were discontinued. On a health care provider ordered a due to behavioral changes. On at 12:48 pm he was having a hard time with his community friend on the previous	{A 025}		

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{A 025}	Continued From page 5	{A 025}		

night and refused meals and medications. His , was "a bit high" so emergency medical services (.) was called. They determined his , was within normal range. On that morning he refused to come to his usual place for meals, so it was taken to his room. His daughter was called, and she spoke with him. He drank his nutrition shake and a cup of milk.

On at 12:42 pm he was having difficulty breathing and was agitated. He refused to be sent to the hospital. His son was called and advised the staff to give the resident a nutrition shake to drink, have him sleep and he would be fine. He was rechecked and was found unresponsive with labored breathing. His doctor was called, who instructed that he be sent to the hospital, but the resident refused to go. The staff were unable to reach his son. A health care provider ordered a hospice consult.

On 6:05 pm a hospice evaluation was done, and it was determined he was not eligible for readmission at that time.

On at 11:03 am he was having increased . His medications were given around 9 am and the nurse determined that he was having slight . The nurse was then notified that his had increased. The nurse returned to assess him and take his vital signs. His , was , saturation was 91. His daughter declined sending him to a hospital and said she'd call a family doctor and get with the nurse.

On a health care provider ordered , 500 mg twice daily for five days for a suspected . Check his ,

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{A 025}	Continued From page 6 and rate twice daily for seven days. Review of his MOR and facility notes revealed there was no documentation to indicate his , and rate were checked on . On at 4:29 pm he had not eaten all day and said he had been drinking his Ensure drinks. He said he was having difficulty standing but said he did not want to go to the hospital. He refused to stand with assistance. The physician's assistant (PA) was notified and instructed staff to call . The resident refused to allow his , to be taken, began waving his can in a threatening manner and yelling to get the hell out of his room. His daughter and son were called. was called and upon their arrival, the resident became verbally aggressive and threatened them with his cane. They took his cane away, placed him on a stretcher and transported him to a hospital. On at 1 am he returned from the hospital. On at 10:20 am his son called the facility to report that when he reviewed a summary of the resident's meds, he noted that two of his dad's meds were not on it. The DON discovered that both his , and Chlordiazepoxide were discontinued on resulting in a med error. His health care provider was notified, who ordered to restart them. Review of his MOR revealed he began receiving the Chlordiazepoxide again on and the , on . On at 8:55 pm he was doing well, more stable with no episodes of aggression. He spent	{A 025}		

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{A 025}	Continued From page 7 time with a friend within the facility. He was tolerating meals and meds. On at 1:27 pm, his daughter said when the resident was in the hospital on he exhibited severe behavioral changes. He was combative with the staff, screaming, cursing, scratching his arms and , and slapping the of his . It was then that she reviewed his med list from the facility and saw he was not being given his , and Chlordiazepoxide. She believed this contributed not only to his behavior changes but also to him not eating. She said when he's having trouble eating, he will only drink his shake. On at 3:28 pm, his PA said the resident's behavior changes and not eating were, she believed, withdrawal symptoms as a result of the Chlordiazepoxide being abruptly stopped. She said it cannot be abruptly stopped and has to be weaned off for at least one month. She said she had no idea he was not getting it. She said his baseline was agitation towards the facility's staff at times. She visited with him today and said he was not agitated and was making jokes. On at 4:20 pm, the administrator said she could not provide documented proof that his , and rate were checked on . On at 6:15 pm, nurse E said the medication error occurred because the meds were "linked" together in point click care which caused the staff to have to take extra steps in order to sign the MOR. The nurse said she removed the meds from the system on with the intent of putting them in so they were no longer linked. She was called away for	{A 025}		

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{A 025}	Continued From page 8 an emergency before she could finish and never put them in. Class II	{A 025}		