

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's _____ to the Federal Bureau of Investigation for a national criminal history record check unless the person's _____ are enrolled in the Federal Bureau of Investigation's national retained print _____ notification program. If the _____ of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit _____ electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the _____ to the Federal Bureau of Investigation for a national criminal history record check. The _____ shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print _____ notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person _____. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	CZ816		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
CZ816	Continued From page 1 professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if _____ for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, _____, herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service	CZ816			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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
CZ816	Continued From page 2 s/Background_Screening/Regulations_Forms.sht ml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if _____ for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to _____ to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the _____ report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 2 of 5 sampled staff completed An Attestation of Compliance with Background Screening Requirements (A & F).	CZ816		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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
CZ816	Continued From page 3 Findings: 1. Review of caregiver F's personnel record revealed a hire date of . The record did not contain a completed Attestation of Compliance with Background Screening Requirements. On . at 3:25 pm, the business office manager was unable to provide additional documentation. 2. Review of Caregiver A's record review revealed a hire date of . There was no evidence documented of a signed background screening compliance attestation. On . at 2:52pm - The Business Office Manager confirmed the findings. Unclassified	CZ816		
A 000	Initial Comments Complaint investigations #2023001365, #2023002116, #2023009686, #2023009995 and #2023010725 were conducted at Brookdale Wekiwa Springs on , and The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 4 of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 010	Continued From page 5 term "bedridden" means that a resident is confined to a bed because of the inability to: - Move, turn, or reposition without total physical assistance; - Transfer to a chair or wheelchair without total physical assistance; or - Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 6 criteria, a resident must have a ...-to-... medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a ... may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A ... ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 010	Continued From page 7 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for assistance with self-administration of medication for 1 of 5 sampled residents (#10). Findings: A record review revealed a facility's admission date of . A health	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 010	Continued From page 8 assessment form (1823) indicated the resident is able to self-administer Medications. On _____ at 1:20pm - Med Tech A was observed conducting a medication pass for resident #10. On _____ at 1:20pm - Resident #10 stated the staff just brings me my meds and I just take them. On _____ at 12:40pm - The Administrator stated after reviewing the 1823 Health Assessment and the Order Summary Report which indicates resident #10 needs assistance with self-administration of medications. "Its hard to believe that occurred and why they would contradict". I'll see if I can get a new 1823. I guess I'll call the doctor. On _____ at 2:30pm - The Administrator stated, no answer for the 1823 or at least no good one. Class III	A 010		
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	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 9 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 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	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 10 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 and ensure safety through proactive measures to minimize the potential for falls and injuries for 1 of 11 sampled residents and failed to ensure the same resident received a medication as prescribed by a health care provider (#1). Findings: Review of resident #1's record revealed a facility admission date of _____. His medical history included _____, moderate _____ and lack of personal safety due to _____. A _____ facility risk evaluation scored him a level 3 (high risk). During an interview on _____ at 10:35 am, resident #1's family member said the resident lived at the facility since _____. She said he was aggressive when he was first admitted but was doing better now that he was on medications. She said during the first month of his stay he was sent to the hospital five times for _____ and twice for aggressive behavior. A _____ 1:48 pm facility note indicated he became aggressive with a caregiver when she redirected him to the bathroom to change his	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 11 brief. A 9:35 pm facility note indicated he was found by med techs on his and on the floor of the memory care living room. He had been sitting in the chair and leaning forward with his arms on his prior to the He refused previous attempts to go to bed multiple times by multiple staff members, getting agitated and yelling at staff for bothering him. He was assisted to sitting in the chair. A lump was forming on the right side of his forehead with a small amount of which was stopped. He said "No, I'll be fine. I don't need to go anywhere". Emergency services was called and he was transported to a hospital. A 12 pm facility note indicated he returned from the hospital. A 2:49 pm facility note indicated he was observed having difficulty ambulating with grimacing. His left was and reddened. The doctor was contacted and informed that the resident's family member said the resident had in the past. A facility note indicated that at approximately 2:10 pm he went into another resident's room while that resident's family member was in the bathroom. When the family member walked out she saw resident #1 going towards the other resident's bed. The family member tried to redirect resident #1 but he came towards her and "daughter to left". He was aggressive with caregivers also after trying to redirect him. He was sent to a hospital. A 1:52 pm facility note indicated he returned from the hospital. His gait was steady.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 12 A 8:05 am facility note indicated that during the evening shift he became agitated and aggressive to a female resident. He had to be redirected and watched by staff to make sure that he did not go after the female resident. Staff had to sit by and stand watch to ensure nothing happened. A facility note indicated he had no redness on his left lower leg and foot. The resident had improved but he was still unable to wear a shoe on his left foot. A 2:01 pm facility note indicated that staff continued to redirect him and assess him for changes in his mood and behavior. His mood was increased due to increased agitation and having struck another resident's family member. He was agitated throughout the unit and staff were able to redirect him by cueing him to help with a task. If he was resistant staff had to continue to verbally redirect him as when staff utilize touch for redirection, he became agitated. His family member would come to the facility and assist with calming him. A 2:36 pm facility note indicated he was agitated during the shift and aggressive with caregivers as he had difficulty being directed to go to the bathroom. Staff was given and effective. A post- evaluation follow up analysis had no prevention interventions. A 10:37 am facility note indicated he was aggressive with a night shift caregiver. The resident did not want to be changed and was redirected to the bathroom when he punched the	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 13 caregiver on his left The resident sustained a on his left On a health care provider ordered 1 milligram (mg) every bedtime and discontinued 0.5 mg every bedtime and discontinue 0.5 mg dose to 1 twice daily as needed for agitation. A 6:20 am facility note indicated he was found on the floor by a caregiver at approximately 6:15 am. He had to his and left He was and said he did not He wore nonskid footwear. He was unable to verbalize what happened. He was sent to a hospital. A post- evaluation had no prevention interventions. A post- note indicated he was very and A health care provider was notified and the doctor would be looking to see what medication adjustments could be done. A facility note indicated that at approximately 12:40 pm he returned from the hospital. He had a on his and on his left and A 9:07 pm facility note indicated he was being assisted to the bathroom when he became agitated. A med tech was in the bathroom trying to get him to change his pants when he began to fight staff. He sustained a on the top of his left The nurse tried to get him into the bathroom but he tried to slap the nurse in the A facility note indicated that at	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 14 approximately 11:40 pm a caregiver went into his room and found him laying on his _____ on the floor with discoloration and a slight bump on his _____. He was unable to say what happened due to _____. He was _____ and _____. He had _____ on both _____ and arms. Non-skid footwear in place. No clutter observed on the floor. Emergency services transported him to a hospital. An additional post _____ note indicated he was near his bed and near the bathroom door. A _____ facility note indicated that at approximately 12:25 pm he returned from the hospital. A _____ post-_____ evaluation initial and follow-up analysis both indicated _____ prevention interventions were a referral to a health care provider and increased frequency of monitoring. On _____ a health care provider ordered physical and occupational therapies for recurrent _____. A _____ 3:04 pm facility note indicated he had an unsteady gait due to his left _____ being _____. A health care provider was notified. A _____ facility note indicated that at approximately 9:30 am he was aggressive with caregivers and residents. He was sent to a hospital. His record did not contain any further occurrence details and no note to indicate he returned from the hospital. On _____ a health care provider ordered _____ 0.5 mg 1 tablet twice daily as needed for _____/agitation. Discontinue _____ 1 mg daily. Increase _____ to 100 mg every bedtime and continue _____ 50 mg every _____.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 15 morning. Start 125 mg twice daily. A 12:18 pm facility note indicated he had to be fed his meals. He . . . asleep at times in the dining room. A 2:47 pm facility note indicated he had . . . to his left He was able to walk but his gait was unsteady at times. On a health care provider ordered 5 mg every bedtime. A 3pm-11pm shift facility note indicated he was found on the floor at his bedside. He had a . . . on his right He was unable to explain what happened or what he was doing before the He lived in memory care and was unable to explain the incident. He was walking around his room and the unit independently. A 10:10 pm post . . . note indicated he had a . . . near his bed. He sustained a bump in the middle of his forehead and scratches on his forehead. 911 was called and he was taken to a hospital. The record did not contain a note to indicate when he returned to the facility. A 4:50 am post . . . note indicated he . . . near his bed. He sustained a . . . on his left upper forehead. 911 was called and he was taken to a hospital. Another note indicated he was found on the floor between his bed and the air conditioner. He returned to the facility at approximately 10:25 am. His gait was unsteady and it was difficult to redirect him at times. a post- . . . evaluation had no prevention interventions.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 16 A 12:16 pm facility note indicated he was very and his gait was still a bit unsteady. On a health care provider ordered to assist the resident with wearing proper footwear daily. was changed to 10 mg every bedtime. A 4:10 pm facility note indicated that he had physical and evaluations after his on That he ambulated without assistive devices. would work with him on strengthening but his gait was steady and devices were not indicated. However, he lacked the ability to be educated on safe transferring and ambulation techniques. He had two unwitnessed in his room on The health and wellness director at the time requested a medication review by the pharmacy, the doctor and group. The were discussed with his family, who felt the resident was bored during the day and tended to get antsy and restless at night when it was a quieter day. The health and wellness director collaborated with his family and the activities coordinator to develop activities he would enjoy, such as setting up a small putting green and corn hole on the patio. Staff would also continue to conduct frequent rounds to his needs and ensure his safety. On at health care provider ordered to discontinue 100 mg at bedtime. Change to 50 mg twice daily for with agitation. A 2:17 pm facility note indicated he was seated in a chair in the living room in memory care when the caregiver left to give another	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 17 resident a shower. After showering that resident the caregiver found him on the living room floor, laying on his left side. He sustained a on his left A 2:30 pm facility note indicated he was sleepy as he did not sleep in his bed on the previous night but wanted to sleep in a recliner instead. His family inquired about side rails. The nurse informed the family that the facility did not allow them. The resident was ambulating to his normal limits independently. On a health care provider ordered to decrease to 50 mg twice daily. On a health care provider ordered to change to 25 mg every morning and 50 mg every bedtime due to recurrent and A 11:47 am note indicated his recent were attributed to the recent medication changes, as his behaviors had greatly improved but his increased instability and increased in the evening. His was adjusted with the current order being 25 mg every morning and 50 mg every bedtime. The caregivers will continue frequent rounding especially in the evening, continue early bedtime routine and assess for effectiveness of medication changes. On a health care provider ordered to apply stockings every morning and remove at 6 pm for lower On a health care provider ordered to decrease 125 mg from twice daily to daily at bedtime.	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 18 A 11:57 am facility note indicated he was unable to stand. It took three staff members to change him after breakfast. Two had to hold him up while the third one changed his brief and cleaned and change his pants. During the process, he became agitated and began to hit the staff. He grabbed one of their arms, pulling and squeezing his into her left arm. Once finished he calmed down. A 4:10 pm "late entry" facility note indicated that at approximately 4 pm he was observed by a staff member slowly reaching for his sock while seated in the common area living room. Another resident's family member witnessed him slowly to his. As they approached him he continued to go forward. A nurse was called to the location. He was observed laying on his left side and was unable to explain what happened due to. The area was well lit and no spills or clutter were present. He wore proper footwear on his left and he removed the sock from his right. A 5:01 pm facility note indicated he had in both making it difficult to walk and he was agitated at times due to this. On a health care provider ordered 20 mg every morning x14 days for right lower. Review of his medication observation record revealed this order was not listed as ever being given. During an interview on at 1:51 pm, the health and wellness director said the was not given. A 11:20 am facility note indicated he was	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 19 found sitting on his _____ in his apartment at approximately 11 am. Staff saw him in the room several minutes prior and reported the resident was sitting in his recliner. Upon entering his room, a nurse saw him scooting on his butt on the floor towards the door. He said "Ow, don't touch that" while touching his right _____ to put a shoe on it. Staff noted his _____ to be _____ and the resident usually reported _____ to them. He had a sock on only his right _____. No clutter or liquid was on the floor. Staff assisted him with putting on socks and shoes. Once he was assisted to a standing position he began walking around the room and was assisted _____ to his recliner. Upon notifying his family member, she said "you know what he's been doing, it's like he is scooting out of his chair and then sitting on the floor. That's probably what he did". A _____ and _____ facility note indicated he was ambulating to his normal limits. On _____ a health care provider ordered physical and occupational therapies to teach him to use a four wheeled walker. A _____ facility note indicated that at approximately 2:50 pm he was observed sitting on his room floor near his recliner. He was unable to state what happened. The area was well lit, no spills or clutter observed. He wore proper footwear. Staff last checked on him twenty minutes prior to the _____ and he was sitting in his recliner. No apparent injuries. A _____ post- _____ evaluation had no prevention interventions. On _____ a health care provider ordered _____ 500 mg three times daily for right	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 20 On _____ a health care provider ordered _____ 20 mg daily every Monday, Wednesday and Friday for _____. On _____ a health care provider ordered to increase _____ to 100 mg three times daily and discontinue _____ 125 mg every bedtime. A _____ 8:21 am facility note indicated he was found on his _____ at his bedside. No apparent injuries. A _____ 3 pm facility note indicated he _____ near a chair in another resident's room. No apparent injuries. A _____ post-_____ evaluation had no _____ prevention interventions. Observations made on _____ at 10:18 am revealed resident #1 was sitting in a chair in the memory care dayroom. His _____ was down and his _____ were closed. He spontaneously opened his _____, looked up and made _____ contact with the surveyor. When asked how he was doing he said he was good then asked the surveyor how they were doing. He then put his _____ down and closed his _____. He had _____ stockings on his lower _____. During an interview on _____ at 2:23 pm, caregiver D said there were times resident #1 was more aggressive than other times. She then said "we try to calm him down, tell him what we're doing and leave him alone if he won't do it". She said it took two staff to provide care to him, one holds his _____ and the other cleans him. She said he stands up whenever he wants but he is	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 21 unsteady. She has to run to him. "You have to be vigilant with him and sometimes you're busy. His wife brought him a walker but he could not comprehend what to do with it." She said she walks with him but only with another staff. She said sometimes he does not lift up his when walking and he does not follow safety instructions. She said she did receive general training. When asked if she had risk and prevention training specific to resident #1, such as his frequent medication changes, difficulty walking, history of and aggressive behaviors, she replied "no". She did not recall ever seeing a service plan for him. She said on her shift there is one caregiver and one med tech. She said that if both are in a room, the other residents are not supervised. During an interview on at 2:55 pm, nurse B said that when resident #1 was first admitted he was agitated, had difficulty walking due to and was not able to verbalize his needs. She said he was high risk for due to the and he was new to the facility, he was agitated and was unable to verbalize how he felt. She did not receive training specific to him. She received the facility's general training. Her own prevention strategies included redirecting the residents, ensuring they use their assistive device, proper footwear and tells the caregivers to make sure the resident wore shoes. During an interview on at 3:37 pm, caregiver H said resident #1 was sometimes aggressive but he'd never seen him be aggressive towards other residents. He said he received training on but not specific to resident #1. His own preventions strategies were "if I have a problem I call a nurse". He said he checks resident #1's medications to see	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 22 they're all there or he reorders them. He said resident #1 needs more than two people to provide care to him. He said three staff work in memory care during the 3pm-11pm shift. He said "everybody keeps ... on the resident cause he walks". Observations made on ... at 3:55 pm revealed resident #1 was walking in the memory care hallway with his ... on the ... rail. He wore tennis shoes. His posture was stooped. His words were nonsensical. On ... at 4 pm a review of resident #1's service plan located in a memory care cabinet revealed it did not indicate he was at risk for nor did it have ... prevention strategies. During an interview on ... 9:30 am caregiver E said, when asked about resident #1's ... , "his ... were ... , he would just ... like that. His left ... was ... for a long time". He said he was not trained on ... specific to the resident. During an interview on ... at 12:10 pm, nurse C said it took two to three staff to provide care to resident #1. She said the resident was aggressive towards other residents, that he'd go up to them, fisted and angry. Staff redirected him but it was not always easy to. She'd never seen him actually hit another resident. She said his gait was unsteady at times, he'd urinate on the floor and slip. She said the resident's ... occurred mostly in his room and if staff were not watching him they would not know he ... She instructed the caregivers to put rubber soled socks or sneakers on him. She said her ... prevention strategies for him were to tell his doctor of the ... and see if his meds could be checked. She did not receive ... training specific to him. She	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 025	Continued From page 23 did receive general . . . training. She said she told the prior director of nursing that she believed the resident was not appropriate to remain in the facility because there were not enough staff to watch him. The facility's . . . policy, most recently revised . . . , read, in part, a . . . refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury. A post . . . evaluation is completed after a resident . . . individualized interventions are considered and the evaluation is a part of the resident's record. The service plan is reviewed for potential interventions and updated as necessary. Discuss resident . . . at the next collaborative care review (CCR) meeting. Review of an . . . CCR report revealed the resident's . . . were discussed, that he had two . . . with a . . . injury and both resulted in treatment at a hospital. The nurse action plan was to work with a doctor and . . . to manage his aggressive behaviors. Review of a . . . CCR report revealed his . . . were discussed, that he had three . . . one with a . . . injury. The nurse action plan was that his appetite and participation in meals was improving along with improvement in his behaviors after medication adjustments. Resident #1 was admitted to the facility on . . . with a documented medical history of . . . moderate . . . and a lack of personal safety due to Soon after his admission, the facility identified him as high risk for . . . based on a risk evaluation. Since his	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 025	Continued From page 24 admission he's had ten . . . , at least four of which required a hospital visit due to injuries. He's had frequent changes to his medications, he's been consistently aggressive towards staff and other residents and exhibited difficulty in walking with noticeable . . . and redness to his left The facility's own documentation following each . . . had a lack of . . . prevention strategies. Staff interviews revealed they all denied receiving training specific to this resident despite his multiple . . . and risk factors. Class II	A 025		
A 030 SS=G	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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 25 residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, 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- _____ 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. (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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 26 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. 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.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 27 (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. (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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 28 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 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. (I) 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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 030	Continued From page 29 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 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and 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 incompetent or incompetent 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 observations, record reviews and	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 30 interviews, the facility failed to honor resident rights by failing to maintain a safe living environment, free from resident-on-resident for 1 of 11 sampled residents (#7). Findings: 1. During an interview on _____ at 2:33 pm, resident #7's family member said another male resident at the facility punched resident #7 in his _____ while the two of them were at a memory care dining room table, which resulted in resident #7 being sent to a hospital. Review of resident #7's record revealed a facility admission date of _____. His medical history included _____. A _____ 1:13 pm facility note indicated he was standing in the dining room about to sit down at the table for lunch when staff witnessed another resident (#11) walking towards another table, passed resident #7 and began yelling. The other resident then used his _____ to push resident #7, who went backwards into a chair. The other resident was immediately removed from the dining room and calmed down by staff. Resident #7 denied _____ and did not have any signs and symptoms of being emotionally upset over the incident. A _____ 10:40 am facility note indicated the nurse was informed by a med tech that resident #7 was sitting in the dining room eating breakfast when staff witnessed another resident (#11) hit resident #7 in his _____. The other resident was immediately removed from the dining room and calmed down by staff. Resident #7 was assessed by paramedics and the facility nurse with no adverse findings. He had redness to his _____.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 31 and all of his were intact. He denied , or discomfort. A hospital after visit summary indicated resident #7 was seen for battery and a injury due to A 1:59 pm facility note indicated resident #7 moved out of the facility. 2. Review of resident #11's record revealed a facility admission date of His documented medical history included 's A 1823 health assessment form indicated he required 24-hour nursing or care and he "occasionally loses temper". A 8:05 pm facility note indicated he was very agitated and became very aggressive to staff and residents. He threatened to punch residents in the and yelled at the med tech to "shut up". He would calm down for a few minutes then threaten someone else. 911 was called. He was taken to a hospital. A 3 am facility note indicated he returned from the hospital. A facility note indicated that at approximately 3:10 pm he tried to punch another resident. Staff redirected him and calmed him down. A 8:48 am facility note indicated staff saw him become agitated and hit another resident in the The med tech said the hit was not hard. He went to hit the other resident again but was stopped by staff.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 32 A 2:44 pm facility note indicated he tried to punch another resident seated next to him at a dining room table. He hit the other resident in the forehead as the nurse redirected him. The other resident had no injuries. A facility note indicated he had a disagreement with another resident and pushed that resident on at 4:03 pm. Staff redirected and separated the two of them. An 4:33 pm facility note indicated that on the previous night he and another resident had a verbal altercation. Resident #11 then put his in the other resident's then punched that resident on the That other resident tried to hit resident #11 but missed. The two of them were separated. An 9:21 am facility note indicated that on the previous night he was seen yelling at a female resident then tried to hit her. He did not make physical contact and was redirected to his room. An personal service assessment indicated he did not demonstrate disruptive, or behavior requiring additional attention. An 7:57 am facility note indicated he began yelling and cursing at another resident. He then proceeded to walk past a different resident and yell, with an expletive, to get out of his way. He then tried to hit that resident but was blocked. He then threw his dinner plate at that same resident but missed. The residents were separated. On a health care provider ordered to discontinue and start 10 mg	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 33 daily for major _____ and _____. An _____ 2:13 pm facility note indicated he was observed insulting and using foul language directed towards a female resident. On _____ a health care provider ordered _____ 0.25 mg 1 tablet every eight hours as needed for _____. On _____ a health care provider ordered _____ (ABH) gel _____ 1mg/25mg/1mg/1ml apply once daily as needed for agitation. A _____ 5:32 pm facility note indicated he became agitated and aggressive when he walked up to another male resident and pushed him. Staff redirected resident #11 but he became verbally aggressive towards some of the female residents. On _____ a health care provider ordered _____ 1 mg x1 dose for aggression/agitation. A _____ 8:42 pm facility note indicated he became agitated and began yelling at other residents. On _____ a health care provider discontinued _____. On _____ a health care provider ordered a hospice consult for _____ and start _____ 25 mg ½ tablet in AM and PM for aggression. A _____ 3:20 pm facility note indicated he was very aggressive towards female residents, using foul language and threatening them.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 34 On _____ a health care provider ordered _____ 0.5 mg 1 tab every six hours as needed for _____ and/or agitation. A _____ hospice/facility integrated plan of care documentation indicated the facility reported agitation and restlessness especially at night. _____ consult was completed at the facility, and they recommended _____ and ABH cream for agitation. On _____ a health care provider ordered _____ 25 mg 1 tablet twice daily for _____. On _____ a health care provider discontinued _____ per family's request. On _____ a health care provider ordered _____ 2mg/ml liquid, give ¼ ml (0.5 mg) every twelve hours as needed for agitation. On _____ a health care provider ordered _____ 50 mg every AM for _____ 25 mg every lunch time for _____ and _____ 50 mg every HS for _____. Psych consult ASAP. A _____ 1:38 pm facility note indicated he was witnessed walking into the dining room and as he passed another resident (#7) who was about to sit in a chair, he began yelling at the other resident then pushed him against the causing the resident to _____ backwards into the chair. Three separate _____ facility notes indicated he was sitting calmly in the dining room during breakfast. He unprovokingly looked over and hit another resident (#7) in the _____.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 35 A hospital after visit summary indicated his visit was for behaviors, that he punched another resident. A 3:40 pm facility note indicated he returned from the hospital. A 4:34 pm facility note indicated the administrator at the time told the resident's family that a notice of immediate discharge from the facility would be issued and until other arrangements were made, he would have to have a private sitter 24 hours a day. A 12 pm facility note indicated he moved out of the facility. During an interview on at 2:23 pm, caregiver D said she did not remember receiving training on the facility's policy. She said if a resident-to-resident altercation took place she calls for a nurse, redirects the residents and takes them out of the situation. During an interview on at 2:55 pm, nurse B said she received training on She said if a resident-to-resident altercation occurs she redirects them. She said you must make sure it does not get to that, especially in memory care. During an interview on at 3:37 pm, caregiver H said if a resident-to-resident altercation occurs, he separates them and calls a nurse. During an interview on at 12:28 pm, nurse B said resident #11's behavior was unpredictable. She always told the caregivers to redirect him as soon as something started, approach him calmly and speak with a soft tone.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 36 She said staffing levels were not increased due to the resident's aggression towards other residents. She said he ambulated independently and would not sit down so staff could watch him. During an interview on _____ at 2:17 pm, caregiver E said that he witnessed the altercation between residents #7 and #11 on _____. He observed resident #7 go to resident #11's table and began softly talking. The caregiver said resident #11 was already agitated and punched resident #7 in his _____. The caregiver said he then called a nurse. He also said resident #11 was aggravated with everyone. He said, "I just leave him, stay away from him". He said if resident #11 became aggressive with another resident he told a nurse. He said there was not enough staff to watch resident #11. He said on the day of the incident, only he and another staff member were working, and he was the only one present in the dining room when the altercation took place. The facility's _____ revised _____ policy read, in part, that if an incident involves resident on resident contact, both residents should be separated and evaluated for a change in condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors. The resident assessment and service plan should be updated as appropriate. A _____ 1823, which was prior to resident #11's admission on _____, indicated he required 24-hour nursing or _____ supervision, making him ineligible for admission to an assisted living facility. In addition, the same form indicated "occasionally loses temper". Shortly after his	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 030	Continued From page 37 admission, he began regularly exhibiting physical and/or verbal aggression towards other residents. It was not until he physically assaulted resident #7 twice within a two-day period that the facility issued a discharge notice and required the family to provide 24-hour private sitters. Class II	A 030		
A 052 SS=D	429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 052	Continued From page 38 or her (d) Applying medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 052	Continued From page 39 administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 40 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility. 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record. 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's _____ control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow proper medication - assistance with self-administration of an improper med pass for 3 of 3 sampled	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 052	Continued From page 41 residents (#4, #5, #10). Findings: The facility's Medication & Treatment - Administration/Assistance policy states the individual assisting and or administering the medication should check the label three (3) times to verify the right medication, right dosage, right time, and right method of administration before giving the medication. The individual assisting with the medication should observe the resident ingesting the medication prior to documenting the administration/assistance on the resident's Medication Record or eMAR and record it immediately after medication assistance. Review of residents #4 1823 revealed she required assistance with self-administration of medication. On at 1:27pm - Med Tech A failed to administer the medication or state the dose to be instilled in each . Med Tech A handed the bottle of Refresh with a tissue to the resident. On at 1:29pm - Med Tech A stated the resident required 2 drops in each . After review of the Medication Administration Record, it revealed Resident 4 order states to instill 1 drop in both . On at 1:30pm - Med Tech A stated she was advised in her training she does not have to state the name and dose unless the resident ask, and she is not allowed to administer the . On at 1:30pm - Med Tech A	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 052	Continued From page 42 confirmed she was a med tech and had received the proper training for Med Pass. On at 12:52pm - The Administrator stated I don't know the answer to that. 2. Review of residents #5 1823 revealed she required assistance with self-administration of medication. On at 10:39a resident #5 was observed in her room with a cup which contained 1 pills left unsupervised for her to take. The resident stated the staff administers her medications and they left the cup for her. Resident #5 stated they do not tell me what I'm taking. There is so much to take so I take a break. The resident stated the remaining pills were 1 and or . On at 1:01pm - Med Tech A stated she had received the training for medication administration and med pass training. Med Tech A stated, I take the cart to the room, knock to inform, and identify resident of medication to be taken. For Resident #5, I do and first, confirm the meds to the Medication Administration Record, pop the pills in the doorway in resident's view. I went to the cart because I forgot the because its PRN. I watched the resident put the pills in her . She has about pills. Med Tech A stated she provides the name and dose of the medications. On at 1:03pm - Med Tech A stated she did not watch her drink water after she placed the pills her . I left out of the room. On at 12:52am - The Administer	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 052	Continued From page 43 stated, yes, I did hear that and it's frustrating that they did not follow the training. I really don't have much more I can say on that. 3. Review of Residents #10 1823 revealed he is able to self-administer medications. On at 1:20pm - Med Tech A failed to state the doses of 2 administered medications. On at 1:22pm - Med Tech A stated she was advised in her training she does not have to state the name and dose unless the resident ask. On at 1:23pm - Med Tech A stated she had received the proper training for Med Pass. On at 1:20pm - Resident #10 stated the staff just brings his meds and they do not state the name or dose. On at 12:52pm - The Administrator stated yes, I heard that occurred and can't provide any more on that. There was training a few weeks ago here at the facility by the staff. So, I'm not sure why that was said. Class III	A 052		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 055	Continued From page 44 prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 055	Continued From page 45 by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may be disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 055	Continued From page 46 dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the facility failed to ensure 1 of 1 resident received assistance with self-administration. (#6) Findings: Review of resident #6's 1823 revealed the resident needs assistance with self-administration. On at 10:35am - Resident #6 was observed in her room and several unsecured medications were identified. The resident stated the staff does her medications, but stated she sometimes has an upset and takes the and uses the Refresh due to recently having surgery. On at 10:37am - The Business Office Manager informed the resident she would have to take the medications and give to the nurse. The resident was informed that they would reach out to her doctor to get orders and then the medications would be returned. On at 10:40am - Nurse C stated the resident went out with her daughter yesterday and must have picked them up. On at 3:17pm - Nurse B stated nobody informed her about the medications in Resident #6 room and she was not aware of resident #6 doing her own medications.	A 055		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 055	Continued From page 47 On _____ at 12:52pm - The Administrator stated, I believe I heard briefly about it. Class III	A 055		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEKIWA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 078	Continued From page 48 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure 2 of 5 sampled staff submitted a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable . . . within 30 days after	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 078	Continued From page 49 beginning employment (A and F) and failed to ensure the personnel record for 1 of 5 sampled staff contained evidence of a negative examination on an annual basis (D). Findings: 1. Review of caregiver F's personnel record revealed a hire date of The record did not contain a written statement from a health care provider documenting that the caregiver did not have any signs or symptoms of communicable 2. Review of caregiver D's personnel record revealed a hire date of The record contained an written statement from a health care provider documenting the caregiver did not have any signs or symptoms of communicable The record did not contain evidence of a negative . . . exam annually thereafter. During an interview on at 3:25 pm, the business office manager was unable to provide additional documentation. Review of Caregiver staff A's record review revealed hire date There was no documented evidence of the Communicable statement. On at 2:52pm - The Business Office Manager confirmed the findings. Class III	A 078		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE WEKIWA SPRINGS

203 S WEKIWA SPRINGS ROAD
APOPKA, FL 32703

AHCA Form 3020-0001
STATE FORM

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 161	Continued From page 51 maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed	A 161		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/03/2023
---	--	--	--

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 161	Continued From page 52 staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure the record for 1 of 5 sampled staff contained a copy of the employment application, with references furnished (A.) Findings: Review of Caregiver staff A's record review revealed a hire date of _____. There was no documented evidence of the employment application with references. On _____ at 2:52pm - The Business Office Manager confirmed the findings. Class III	A 161		