Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964810	A. BUILDING: _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CONWAY	5501 EAST MICHIGAN STREET ORLANDO, FL 32822

(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
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

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

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to electronically submit a one (1) day adverse incident report to the agency for 1 of 3 sampled residents (#1) as required after a significant occurrence in a timely manner. Findings: A facility incident report dated , revealed that resident #1 had just finished her lunch and was seen self-propelling via wheelchair away from the table as staff was cleaning up. Resident #1 tried to stand up on her own from the wheelchair and to the floor on her right side resulting in a to her . A facility note dated at 1 PM by nurse A documented she was called to resident #1's room and observed her on the floor. Resident #1 was sitting in her wheelchair in dining room, and she stated that she stood up and tried to walk, when she landing on her right side. Resident #1 complained of right , and , . Unable to move her right , without , 911 was called and the resident transported to the hospital. Notified son and left message to call the facility. Notified the physician.	CZ821		

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CZ821	Continued From page 4 The facility electronically submitted the 1-day preliminary report on . . . . . (three days late) and the 15-calendar full report electronically on . . . . . (four days late, due to the agency on . . . . .). The facility did not submit the required reports timely as required. (Photographic Evidence Obtained) On . . . . . at 5:45 PM, an interview with the interim Administrator and Health Wellness Director confirmed the findings. Unclassified	CZ821		
A 000	Initial Comments Two (2) complaint investigation #2023007832 and #2023009704 and generator monitoring was conducted at Brookdale Conway Assisted Living Facility & Memory Care with Limited Nursing Services (LNS) on . The facility had deficiencies at the time of the survey visit.	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 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	A 010		

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A 010	Continued From page 5	A 010		

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 term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without

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A 010	Continued From page 6 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 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	A 010		

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A 010	Continued From page 7	A 010		

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 [illegible] 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 [illegible] 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;
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

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A 010	Continued From page 8 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 resident record review and interview, the facility failed to obtain a new 1823 Health Assessment for 2 of 3 sampled residents (#1, #2) to reflect a significant change that occurred as required. Findings: 1. Resident #1's record review revealed admission date . The last 1823 Health Assessment dated on listed medical history of , around internal right , fatigue, , in left , difficulty in walking, Hyponatremia, , , Atherosclerotic of left ,	A 010		

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A 010	Continued From page 9 wedge . . , ... , ... , , , ... disturbance, . . . , . . Her physical limitations are hard of hearing and needs to use wheelchair for long distances. She needs assistance with activities of daily living (ADLs) ambulation, . . , bathing, toileting and transferring. Supervision with eating and grooming. She needs assistance with self-administration of medications. In further review, she was recently admitted to Hospice care on . . . . . . There was no documented evidence and no new 1823 Health Assessment for the new admission on Hospice in the file. (Photographic Evidence Obtained) On . . . . . at 3:30 PM, an interview with the Health Wellness Director confirmed the findings. Class III	A 010		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of . . . . . or . . . , ... or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such . . . . . or . . . . . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . . . . . for the	A 025		

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A 025	Continued From page 10 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 that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of	A 025		

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A 025	Continued From page 11 additional services. This Statute or Rule is not met as evidenced by: Based on facility's documentation, resident record review and interview, the facility failed to provide adequate supervision and failed to provide care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for with injuries for 2 of 3 sampled residents (#1, #2) that resulted significant injuries and had prior that could of been prevented; and the facility failed to maintain written documentation after a significant change for 2 of 3 sampled residents (#1, #2). Findings: 1. Resident #1's record review revealed admission date . The last 1823 Health Assessment dated on listed medical history of , around internal , right , fatigue, , in left , difficulty in walking, Hyponatremia, , , Atherosclerotic , of left , wedge , disturbance, , . Her physical limitations are hard of hearing and needs to use wheelchair for long distances. She needs assistance with activities of daily living (ADLs) ambulation, , bathing, toileting and transferring. Supervision with eating and grooming. She needs assistance with self-administration of medications. In further review, she was recently admitted to Hospice care on .	A 025		

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A 025	Continued From page 12 A facility note dated at 12:45 PM by nurse A documented resident #1 arrived to community from skilled nursing home rehabilitation from a and at 12 PM. Resident #1 alert with . Uses wheelchair for mobility. Vitals stable. Mechanical soft diet with nectar thick liquids. Denies any or distress. Skin intact. She ate lunch without any issues. A facility incident happened and reported on , that resident #1 had just finished her lunch and seen self-propelling via wheelchair away from the table as staff was cleaning up. Resident #1 tried to stand up on her own from the wheelchair and to the floor on her right side resulting in a to her . A facility note dated at 1 PM by nurse A documented she was called to resident #1's room and observed her on the floor. Resident #1 was sitting in her wheelchair in dining room, and she stated that she stood up and tried to walk, when she landing on her right side. Resident #1 complained right and . Unable to move her right without . 911 was called and the resident transported to the hospital. Notified son and left message to call the facility. Notified the physician. There were no facility notes when resident #1 returned to the facility with new discharge orders or any intervention to follow up from the right . A facility note dated at 9:16 PM by nurse F documented resident #1 was getting up from wheelchair trying to walk and screaming & yelling to call the police. Resident #1 was combative with staff and was not easy to redirect. Son and	A 025		

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A 025	Continued From page 13 physician notified. A facility note dated [redacted] at 3:40 PM by nurse F documented resident #1 had an unwitnessed [redacted] at 2:30 AM early morning. Staff heard resident #1 yelling for help. Went into resident #1's room and observed resident #1 sitting on floor near the bed, it was checked for injuries. Resident #1 was able to move all extremities. No complaints of [redacted]. No grimacing. Resident #1 had a small [redacted] on his right [redacted]. Notified son and physician. A facility note dated [redacted] at 10:05 PM by nurse F documented resident #1 was observed sitting in wheelchair in dining room earlier during lunch. Resident #1 was trying to get up on her own and ambulate. Resident #1 was encouraged not to get up from wheelchair. Resident #1 was not easy to redirect. A facility note dated [redacted] at 11:25 AM by nurse F documented resident #1 was getting out of bed and when going to wheelchair to stand up, resident #1 [redacted] forward. Resident #1 had a hematoma on forehead with [redacted]. 911 called and resident #1 transported to hospital for evaluation and treatment. Family and physician were notified. A facility note dated [redacted] at 4:30 PM by nurse F documented resident #1 was transported [redacted] from hospital by medical transport. Resident #1 alert with [redacted]. Resident #1 has a right-side [redacted] and small right [redacted], hematoma and [redacted] red, vitals checked stable. A referral made to Hospice. A facility note dated [redacted] at 9:06 PM by	A 025		

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	AL11964810	A. BUILDING: ______ B. WING ______	08/17/2023

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A 025	Continued From page 14 nurse F documented resident #1 alert with . Needs assistance with ADLs of toileting and showers. of and . Medication crushed. Use walker for mobility. Poor intake, pureed diet with nectar thickened liquids. Resident #1 becomes very , yelling and saying she needs to go to her family. Resident #1 on Hospice. lower left . Denies any or discomfort at this time. (Photographic Evidence Obtained) There was no documented evidence that resident #1 now uses walker for mobility as stated in facility note dated . In further review, there was no documented evidence of when the on lower left occurred dated in facility note . There was no safety measure documented put in place to prevent another . 2. Resident #2 record review revealed admission date . The 1823 Health Assessment dated listed medical history of , and insufficiency. Her physical limits are partially visual . She needs supervision with activities of daily living (ADLs) in ambulation with a walker and independent with all others. She needs assistance with self-administration of medications. There was no documented evidence and no new 1823 Health Assessment identifying that she was at a high risk for since her first on	A 025		

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A 025	Continued From page 15 . . . . . . A facility note dated . . . . . at 9:19 AM by nurse F documented while doing rounds at 12:30 AM, opened resident #2's door and observed resident laying on the floor and . from the . . . of her . . . . 911 called, resident sent to hospital. Family and physician notified. Resident #2 returned to the facility from hospital at 3:28 AM with no new orders. A small on the of . . , no . . . . . . Resident #2 denies any . or at this time. A facility note dated at 4:53 PM by nurse A documented resident #2 was ambulating with her walker in the dining room when she got close to another resident pushed her backwards. She landed on the floor on her . No injuries. Resident #2 was assisted off the floor by 2 staff and placed in a chair in the dining room. Denies any , . from the . . The daughter and physician notified. Vitals checked and stable. A facility note dated at 11:17 AM by nurse F documented that on . . . . . but meant on at 5:30 PM, resident #2 had a witnessed . . Resident #2 was in the dining room and lost her balance and . No injury. The daughter and physician notified. There were no facility notes regarding to an additional investigation completed for this , resident #2 said that it was caregiver E's fault (terminated) that she in the dining room because staff E stated to resident #2 that she could not help her right now because she was busy in the kitchen. A facility note dated at 9:38 AM by nurse A documented resident #2 alert with	A 025		

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A 025	Continued From page 16 . . . . . and needs assistance with ADLs in toileting and showers. of and . . . . . Medications crushed. Resident #2 on and INR is checked every two weeks. Resident #2 ambulates with rolling walker and eats all meals in dining room with good intake and regular diet. Resident #2 is being followed by wellness coordinator for dry skin on both . . and a . . . . to left . . Denies , at this time. A facility note dated at 12:26 PM by nurse F documented resident #2 alert with . . . . . Resident #2 is being followed by the wellness coordinator for dry skin on both . . and to left . . Resident #2 has a on the left upper arm. HHA now following resident #2 for care. Resident #2 denies , at this time. A facility note dated at 7:52 PM by nurse F documented around 7:15 PM found resident #2 sitting on the floor in the middle of her doorway. Unwitnessed . . Resident #2 has a large bump above left , , no . . Doctor and family notified. The doctor said send resident #2 out to hospital because she is in . 911 called. A facility note dated at 7:41 PM by nurse F documented that resident #2 returned to the facility from hospital at 5:30 AM this morning. Resident #2 had a CT of . . . and . , ... , and . . Resident #2 had a hematoma to . . . , with . . . . . to left side of . . . and . . . . Resident #2 denies , and no grimacing noted. (Photographic Evidence Obtained) There was no safety measure documented put in place to prevent another . .	A 025		

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A 025	Continued From page 17 In further review of the facility's policy and procedures, there was no evidence that a assessment was completed and precaution interventions put in place by the facility, that the facility's policy clearly states on page 1, section A regarding the assessments and page 2, section B for the interventions for resident #1 and resident #2 above. On at 6:10 PM, an interview with the interim Administrator and Health Wellness Director confirmed the findings. Class III	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at	A 032		

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A 032	Continued From page 18 risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.	A 032		

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A 032	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on observation, resident record review and interview, the facility failed to make a daily effort to check if 1 of 3 sampled residents (#2) had the identification bracelet on their person that includes the resident's name, facility's name, facility's address, and facility's telephone number as required for residents' high risk for elopement. Findings: Resident #2 record review revealed an admission date . The 1823 Health Assessment dated listed medical history of , and insufficiency. Her physical limits are partially visual . She needs supervision with activities of daily living (ADLs) in ambulation with a walker and independent with all others. She needs assistance with self-administration of medications. In further review, resident #2 was identified as an elopement risk. An observation on at 3:40 PM, resident #2 was not wearing an identification elopement bracelet. A review of the facility's elopement policies and procedures on page 1, section 2a states that residents assessed at risk for elopement, or any history of elopement should have an identification on their persons that includes their name, the facility's name, facility's address, and facility's telephone number. On at 4 PM, an interview with the interim Administrator and the Health Wellness	A 032		

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A 032	Continued From page 20 Director confirmed the findings. Class III	A 032		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1).	A 081		

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A 081	Continued From page 21 (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.	A 081		

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A 081	Continued From page 22 (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . ., neglect, and , . The facility must use its . . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by:	A 081		

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A 081	Continued From page 23 Based on personnel record review and interview, the facility failed to ensure that 3 of 5 sampled staff (A, D, E) completed the required staff in-service training. Findings: 1. Nurse A's personnel record revealed a hire date of . . . . There was no documented evidence that the 2-hour pre-service orientation training was completed prior to interacting with the residents. 2. Caregiver D's personnel record revealed a hire date of . . . . There was no documented evidence that the 2-hour pre-service orientation training was completed prior to interacting with the residents; and no documented evidence that 1 hour . . . . . , neglect training completed within 30 days of employment along with 3 hours of Activities of Daily Living and behavioral training and 1 hour reporting major incident and emergency procedures. 3. Caregiver E's personnel record revealed hire date and terminated on . There was no documented evidence that the 3 hours of Activities of Daily Living and behavioral training and 1 hour reporting major incidents and emergency procedures were completed within 30 days of employment. On . . . . . at 5:30 PM, an interview with the Business Office Manager confirmed the findings. Class III	A 081		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD	A 086		

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A 086	Continued From page 24 (10) . . . . . AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , . . and , , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " . . . . . and Related Level I Training," must address the following subject areas: 1. Understanding 's and related . . . . . ; 2. Characteristics of ; 3. Communicating with residents with . . . 's ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility . . . . . and Related . Level I Training. (c) Facility staff who provide direct care to	A 086		

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A 086	Continued From page 25 residents with ADRD must obtain an additional 4 hours of training, entitled " and Related . . . . . Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. . and Related . Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with . . . . 's . . . . . and Related ," dated . . , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of	A 086		

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A 086	Continued From page 26 employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or 2. Three years of practical experience in a program providing care to persons with or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 2 of 5 sampled staff (A & C) completed the required 4 hours annual update in 's and Related (ADRD); and the facility failed to ensure that 1 of 5 sampled staff (B) completed the 4 hours Level one training within 3 months of employment and 4 hours Level two within 9 months of employment as	A 086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964810	A. BUILDING: _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CONWAY	5501 EAST MICHIGAN STREET ORLANDO, FL 32822

(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 086	Continued From page 27 required. Findings: 1. Nurse A's personnel record revealed hire date . She completed her 4 hours Level one training on and the 4 hours Level two 's training on . There was no documented evidence that the 4 hours annual update for 's training was completed for 2021, 2022 and 2023, the last 4 hours annual 's update was completed on . 2. Caregiver C's personnel record revealed hire date . She completed her 4 hours Level one training and the 4 hours Level two training on . There was no documented evidence that the 4 hours annual update for training was completed for 2021, 2022 and 2023, the last 4 hours annual update was completed on . 3. Caregiver B's personnel record revealed hire date . There was no documented evidence that 4 hours Level one 's training and 4 hours Level two training completed in the record as required. On at 5:30 PM, an interview with the Business Office Manager confirmed the findings. Class III	A 086		