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 |
|---|---|---|---|
| | AL11964946 | A. BUILDING: _____ B. WING _____ | 08/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE MELBOURNE | 1765 WEST HIBISCUS BLVD MELBOURNE, FL 32901 |

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| A 000 | Initial Comments<br><br>A complaint investigation #2023007507 was conducted on [redacted] at Brookdale Melbourne. A deficiency was found at the time of the visit. | A 000 | | |
| A 025 SS=G | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. | A 025 | | |

AHCA Form 3020-0001

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

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| A 025 | Continued From page 1<br><br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to provide care and services and the general awareness whereabouts of a resident who was assessed as an elopement risk for 1of 3 residents (#1).<br><br>Findings:<br><br>In a review of resident#1's health assessment dated and an admission date of revealed a medical history of 's, , Generalized , , . Resident required assistance with daily living to include supervision with ambulation, bathing, _, eating, self-care, toileting, transferring. The resident resided in | A 025 | | |

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| A 025 | Continued From page 2<br><br>memory care and was a elopement risk.<br><br>In review of the facility notes dated . . . . . at approximately 6pm, resident #2, residing on the assisted living side of the facility, reported to staff D that she observed resident #1 outside her window walking in the grass on the grounds and perimeter of the facility. Staff D immediately notified the memory care staff and staff E and F brought her to the memory care unit. While checking the fire door on the east side of the building in memory care, resident #1 was able to just push the door open with no alarm sounding. The resident was assessed and no injuries noted. Resident was seen 20 minutes prior to incident walking in the hallway. Fire door will be monitored at all times until door alarm is fixed. On door alarm was repaired.<br><br>In review of the facility's elopement policy defines an elopement as any incident where a resident leaves the secured memory care area of the community or the secured courtyard, unescorted, with or without injury.<br><br>In an interview on at 10:30am with resident #2, she stated she saw resident #1 outside her window in her room on the assisted living side. She stated she was standing in the grass. She stated she immediately called the nurse, and the staff came right away and brought her into the building<br><br>In an interview on at 11:30am with Staff A, stated she has been here a 1 year and she has done 2 elopement drills but not sure what the elopement policy is but has been to a lot of meetings. She stated she would call management and check for the resident. She was not sure of the procedure. She stated resident #1 | A 025 | | |

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| A 025 | Continued From page 3<br><br>did not have her bracelet on because she take it off often. She stated she checks her when she gets her up to dress her. She stated they do check the doors in the memory care unit to make sure they are locked, and the alarm works.<br><br>In an interview on [redacted] at 12:30 with Staff D stated the facility does elopement drills frequently and goes over the policies. She stated she has done at least 2 this year. She stated resident #1 is not [redacted] she likes to walk the halls, but she is calm. She stated she is not sure what made her go out the door that day. She stated she is not exiting seeking. She stated there was a lightning storm and for some reason that door did not sound an alarm. She stated the doors are checked now frequently. She stated a [redacted] count was completed that day. She stated she is not sure if the ALF resident did not see her how long she would have been gone. She stated the door has since been repaired. She stated she was not aware that resident #1 was an elopement risk or that door had no alarm at the time.<br><br>In an interview on [redacted] at 12:45pm with Staff E she stated the resident was found outside and was able to get out when they were serving dinner. She stated resident #1 already had her dinner and always likes to walk around after she eats. She stated she did not observe her after she left the dining room. She stated she was not aware she was an elopement risk. She stated the door had an alarm but after the storm it wasn't working, and they were waiting for it to be repaired. She stated she believes she has completed elopement drills but does not remember when. She stated she is aware of the protocol for looking for an elopement resident and completing [redacted] counts. | A 025 | | |

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| A 025 | Continued From page 4<br><br>In an interview on . . . . . at 12:50pm with Staff F she stated the resident was found walking around the building after she got out through an exit door that had an alarm that was not working at the time. She stated the staff immediately got her when they were alerted. She stated she is not sure how long it would have been till they found her, if resident#2 did not report seeing her. She stated it would have been on the next round which is every 2 hours. She stated the resident never left the property grounds.<br><br>In an interview with the administrator on at 2pm, she confirmed the above statements. She stated the door has since been repaired. She stated at that time there was a lightning storm, and it must have knocked out the alarm on that door only. She stated she has also placed a magnetic screamer on the door for added protection. She stated the staff have completed their elopement drills and they also go over the policy at that time. She stated resident #1 is not an exit seeker and no one knows why she decided to go out the door. She stated she is not sure why she is not wearing her ID bracelet, but staff does check during the day.<br><br>The resident was able to get out of the memory care unit without any of the staff being wawar through a door that the facility was aware that the alarm was not functioning after a lighting storm. Resident #2 who resdients on the Assisted side of the Assusted Living side of the facility alert staff that the resdient was seen outside of her window walking in the grass on the grounds and the perimeter of the facility.<br><br>Class II | A 025 | | |