Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965818	A. BUILDING: _____ B. WING _____	R 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LAKE MARY	150 MIDDLE STREET LAKE MARY, FL 32746

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit survey was conducted at Brookdale Lake Mary on . . . . . . The facility had deficiencies at the time of the survey.	{A 000}		
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 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	A 032		

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A 032	Continued From page 1 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. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to make a daily effort to ensure 1 of 1 sampled resident who was identified as being at risk for elopement had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#7). Findings:	A 032		

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A 032	Continued From page 2 Review of resident #7's record revealed a facility admission date of . A Health Assessment (1823) form indicated the resident's diagnoses of , forgetful, and identified at risk for elopement. A facility note on at 17:00 read, "Resident returned from hospital via family vehicle. 1823 and medication list given to nurse". A facility note on at 15:16 read, "Nurse was walking by the front desk and seen resident walking out of the facility while it is pouring rain outside. Resident stated he does not care he is going to Tampa. 911 was called and resident was sent to hospital". On at 2:23pm Resident #7 was observed in his room. The Activities Director states the that the resident is wearing was his call pendant and only has his room #. The Activities Director states she was not aware of any other that has the resident's name or the facilities information. Resident #7 stated he did not have any other identification on him, nor was any other observed, and he pushes the pendant when he needs the staff. On at 4:25pm The Administrator stated that resident #7 was never alone and someone was with him. The Administrator stated she was with him. The Administrator stated resident #7 did not elope. On at 4:25pm The Administrator stated the doctor at the hospital identified him as elopement risk, but he's not. He was not alone. The Administrator stated she would contact the doctor to get corrected.	A 032		

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A 032	Continued From page 3 On . . . . . at 4:25pm The Administrator stated resident #7 returned over the weekend. I'm not sure who received him . . . to the facility. The hospital should not send someone when there's a medication change like that. The facility's revised policy dated . . . . . states, "Residents living in a non- and . . . . . Care community who have a documented diagnosis of shall also be considered as risk for elopement. Residents assessed at risk for elopement or with any history of elopement should have identification on their persons that includes their name and the community's name, address, and telephone number. The risk for elopement will be identified in the resident's service plan". On . . . . . at 4:25pm After review of the facility's elopement policy, The Administrator stated we will have to put the bracelet . . . on him. The Administrator stated, "no the resident did not have a bracelet on prior to the event and we did not have a chance to update his service plan". On at 4:25pm The Administrator stated, "I was getting a sitter today for him because he is an elopement risk. The Administrator stated we may have to issue a 45-day notice because resident #7 is getting out of ". On at 5pm The Administrator confirmed the findings. Class III	A 032		