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
	AL11965474	A. BUILDING: _____ B. WING _____	10/12/2023

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 000	Initial Comments A complaint investigation survey #2023015210 was conducted on [redacted] and [redacted] at Brookdale Wekiwa Springs. 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.	A 032		

AHCA Form 3020-0001

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

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A 032	Continued From page 1 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. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to follow its resident elopement policy regarding the frequency of conducting elopement drills and failed to make a daily effort to ensure 1 of 1 sampled resident who was identified as an elopement risk had identification (ID) on their person that included the resident's name and the facility's name, address, and phone number (#14).	A 032		

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A 032	Continued From page 2 Findings: Review of resident #14's record revealed a facility admission date of [illegible]. The resident's medical history included [illegible]. A [illegible] 7:05 pm facility note indicated the resident was found outside heading up the parking lot towards independent living in her wheelchair by a kitchen staff's uber driver. The scheduled med tech was giving a shower at the time. The uber driver was coming down the driveway and almost hit the resident. The driver stopped and tried to convince the resident to go [illegible] to the building because he stated, "she looked like she was on the move trying to leave". The resident refused and started heading up the driveway even faster. That's when the kitchen staff member came out to get in the uber and was informed of the situation by the driver. The kitchen staff member brought the resident into the facility. A [illegible] 7:20 pm facility note indicated the resident was found going towards the exit door at the end of 100 hall. When staff tried to redirect the resident, she screamed "no" at the top of her [illegible]. The resident seemed [illegible], but the staff was unable to communicate with the resident due to a language barrier. A [illegible] facility incident report indicated that at approximately 8 am, the resident went to the parking lot unattended and was found by staff looking at the palm trees. The resident made no attempt to leave the property. A [illegible] 2:24 pm facility note indicated the resident's family agreed to move the resident to	A 032		

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A 032	Continued From page 3 the facility's secured memory care unit. On at 11 am and 3 pm, resident #14 was seen without an ID. On at 11:10 am, resident #14 still had no ID on. Nurse B said the resident did not have ID because she was not an elopement risk. During the survey, the clinical services , provided a health assessment form (1823) that indicated the resident was at risk for elopement. The facility's , elopement risk policy defined elopement for assisted living residents as any incident where a resident leaves the interior of the assisted living portion of the community; unescorted or unsupervised, with or without injury, when it has previously been determined that he/she needs supervision. Residents living in a non- care community who have documented diagnoses of shall also be considered at risk for elopement. Residents assessed at risk for elopement or with any history of elopement should have ID on their persons that includes their name and the community's name, address, and telephone number. The policy read, in part, missing resident drills should be conducted quarterly for all shifts. Review of the documented drills revealed they were conducted on (day shift), (day shift), and (day shift). A staff meeting covered elopement drills. On at 11:24 am, the clinical services said regarding the staff meeting, "we	A 032		

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A 032	Continued From page 4 discussed where would you look first, what would you start doing, do a count, go to the front to see if they're signed out, full building sweep, if determined resident not here, call family and home office then police, do parameter checks." She confirmed it was not an actual drill. She also confirmed the lack of drills based on the protocol of the elopement policy. Class III	A 032		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the	A 056		

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A 056	Continued From page 5 medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the	A 056		

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A 056	Continued From page 6 resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were refilled in a timely manner to ensure doses were not missed for 2 of 11 sampled residents who required assistance with self-administration of medications (#12 and #15). Findings: 1. Review of resident #12's record revealed a facility admission date of . An 1823 indicated the resident required assistance with self-administration of medications. On a health care provider ordered 5 milligram (mg) 1 tablet by every bedtime. "09" (other/see nurse's note) was documented on the medication observation record (MOR) on and .	A 056		

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A 056	Continued From page 7 During a medication pass observation on [illegible] at 4 pm, [illegible] was not available to give. On [illegible] at 10:54 am, review of the progress notes provided by the clinical services [illegible], revealed there was not an explanation note for the "09". 2. Review of resident #15's record revealed a facility admission date of [illegible]. An 1823 indicated the resident required assistance with self-administration of medications. Review of the resident's [illegible] MOR revealed both the [illegible] and [illegible] had "09" or "16" (pharmacy action required) documented from [illegible] through [illegible]. On [illegible] at 9:50 am, review of the progress notes provided by the clinical services [illegible], revealed there was not an explanation note for the "09" and "16". The facility's [illegible] how to order medications policy read, in part, that routine medications should be placed on a "cycle" refill, so they are automatically refilled by the pharmacy. If a "cycle" refill is not available, when the resident's medication supply reaches 7 days, fax a refill request to the pharmacy. Contact the pharmacy by phone if the newly ordered/refilled medications do not arrive in a timely manner. On [illegible] at 11:44 am, the clinical services [illegible] said "we're having pharmacy issues. Trying to switch to Guardian. Met with nurses this morning that they have to try to get these refills in the building."	A 056		

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A 056	Continued From page 8 Class III	A 056		