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 _____	04/16/2024

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 000	Initial Comments There were two (2) Complaint Investigations #2024001587; #2024004408, and a 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 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	A 010		

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A 010	Continued From page 1 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 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	A 010		

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A 010	Continued From page 2 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 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,	A 010		

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A 010	Continued From page 3 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; 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.	A 010		

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A 010	Continued From page 4 (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, AHCA Form completed by the healthcare provider for continued residency after a significant change and inappropriate retention for 1 of 4 sampled residents (#3). Findings: 1. Resident #3's record review revealed an admission date of . The last 1823 Health Assessment dated listed medical history of Acute , , Failure with , , Left ankle , Lymphedema, , , , Hyponatremia, , , and , . He needed assistance with all activities of daily living (ADLs) in ambulating, bathing, , grooming, eating, toileting and transferring. His status was assistance with feeding, , hygiene, and toileting ( ). He needed assistance with self-administration of medications. (Photographic Evidence Obtained) A facility note dated at 9:21 AM by Nurse F documented resident #3 was alert with . He needs assistance with ADLs with toileting and showers totally. He was with / . Medications are given crushed without difficulty. Resident #3 uses a wheelchair for mobility and eats all his meals in the dining room. Resident #3 now on pureed diet with nectar thick liquids which is tolerated well. No	A 010		

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A 010	Continued From page 5 behavior issues. No recent or trips to hospital. A facility note dated ordered a , with 2 views. Diagnosis with / causing immobility. On at 4:05 PM an attempted observation for resident #3 to transfer and pivot from wheelchair to the toilet for bathroom break. Furthermore, attempted to wave hello to resident #3 but he did not respond, he did not even know someone was there. He was just peacefully sitting in his wheelchair in the dining room with his peers waiting for the dinner meal to arrive. On at 4:10 PM, an interview with Caregiver I and Unlicensed Caregiver K confirmed that resident #3 can no longer transfer himself or help with transferring from his wheelchair to the toilet. Resident #3 was totally dependent on 2 persons to assist with toileting and baths. The facility no longer gives him showers, gives him bed baths and he wear adult briefs for with and . There was no documented evidence that a new to health assessment was completed by the healthcare provider for continued residency and there was no documented evidence that resident #3 was admitted on Hospice care to age in place in an assisted living facility. On at 4:20 PM, an interview with the Health Wellness Director and Administrator confirmed the findings. Class III	A 010		

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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 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	A 025		

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A 025	Continued From page 7 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 additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide adequate supervision when 3 of 3 sampled residents were involved in resident-to-resident altercations resulting in physical injuries (#1, #2, #11.); and the facility failed to maintain written documentation for a significant change for 1 of 4 sampled residents (#3) as required. Findings: 1. A facility incident report indicated that on at approximately 6:30 pm resident #1 returned to her room after dinner. When she got to her doorway, she saw resident #2 in the room. She told resident #2 to get out of her room. Resident #2 approached resident #1 in the doorway and shoved her causing resident #1 to backwards and land on the floor. A caregiver heard resident #1 yelling, responded to the location then saw the resident on the floor. The	A 025		

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A 025	Continued From page 8 caregiver went to the door of memory care and yelled for nurse A to come. Nurse A arrived to see resident #1 laying on the floor. At 6:45 pm nurse A called 911 because resident #1 was yelling in , . At approximately 7:20 pm emergency medical personnel arrived then transported the resident to a hospital. The report indicated the incident was not witnessed by staff and the details were relayed by resident #1. The residents lived in the facility's memory care unit. A review of resident #1's record revealed a facility admission date of . The resident's medical history included (on ,), , and , . On at 7:53 pm the wellness director documented resident #1 was taken to a hospital due to a the resident reported was caused by another resident pushing her. Resident #1 stated she was going to her room after dinner and upon arriving there she saw another resident in her room. Resident #1 asked the other resident to get out of her room at which time the other resident came towards resident #1 then shoved her to the floor. After the resident #1 yelled out in , multiple times and rated the , as 10 on a scale of 1 to 10 with 10 being the worst. A hospital clinical note indicated resident #1 presented with a left , , multiple and a left- extending to the third and fourth with exposure. A review of resident #2's record revealed a facility admission date of . The resident's medical history included . A health assessment form (1823) indicated the resident experienced memory loss and irritability.	A 025		

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A 025	Continued From page 9 On a health care provider ordered 0.5 milligram (mg) tablet, 1 tablet by as needed for . Repeat after twenty minutes up to four times. On a health care provider ordered 25 mg by three times a day in the morning, noon, and bedtime. On at 12:48 pm nurse F documented resident #2 could be behavioral at times but easily distracted. On at 7:40 pm the wellness director documented resident #2 was involved in an unwitnessed resident to resident altercation following dinner. The staff was in the dining room cleaning up from dinner. Resident #2 left the dining room to go to her room. The staff were completing their final clean up when they heard another resident yell for help. Staff responded and observed resident #1 laying on the floor outside of her room and resident #2 was seen in resident #1's room. Resident #1 stated resident #2 shoved her making her . Resident #2 stated she did not hit resident #1. Resident #2 had not exhibited prior aggressive behaviors. On at 2:52 pm nurse A documented resident #2 was verbally aggressive towards staff. On at 11:07 am nurse F documented resident #2 was verbally at times. On at 9:10 am nurse F documented resident #2 was verbally at times, yelling and swearing at staff and other residents. On at 9:37 am, resident #2 was observed	A 025		

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A 025	Continued From page 10 sitting in a regular chair in the dining room. She was pleasantly . On at 9:51 am, caregiver C said resident #2 had been verbally aggressive towards other residents and she'd never seen the resident be physically aggressive. The caregiver believed there were enough staff on the 7am-3pm shift to adequately supervise the residents. On at 9:55 am, caregiver D also said resident #2 had been verbally but not physically aggressive towards other residents. She also believed there were enough staff to adequately supervise the residents. On at 11:09 am, nurse A said when the altercation occurred between residents #1 and #2, she was called to memory care by one of the caregivers. When the nurse arrived, she saw resident #1 on the floor in the hallway right outside of her apartment door. The nurse said the residents were already separated when she arrived. The nurse checked on resident #1 then called 911 and the resident was transported to a hospital. The nurse said she never witnessed resident #2 be physically or verbally aggressive toward other residents. On at 2 pm, nurse F said resident #2 was verbally towards staff and other residents. The nurse said she never witnessed resident #2 be physically towards other residents. The nurse said resident #2 was usually easy to redirect. The nurse did not feel two caregivers were enough in memory care to provide adequate supervision. She felt there should be at least three caregivers because if two were providing resident care there was no one supervising the other residents.	A 025		

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A 025	Continued From page 11 On at 3:05 pm, caregiver I said resident #2 became easily agitated with other residents who made noises or who called out. The caregiver said resident #2 became verbally towards them, telling them to shut up and cursing at them. The caregiver said resident #2 was usually easy to redirect. The caregiver said if both caregivers on duty have to go in together to care for a resident, they sometimes ask one of the assisted living caregivers to come watch the residents. On at 4:12 pm, the administrator said he was not sure what interventions were put in place following the incident between residents #1 and #2. The wellness director was present and said she spoke with staff regarding the policy, specifically managing resident to resident altercations and aggression. The wellness director said she spoke with staff regarding incident reporting. She said she met with resident #2's family member after the incident. The wellness director's recall was that both caregivers B and J were cleaning the dining room when the incident occurred. The wellness director said no additional staff were scheduled for increased supervision after the incident. She said the staff just tried to do the best they could with the number of staff they had. She said the staff were informed of what was a reportable event. She said that on resident to resident altercation interventions were discussed with staff, they discussed different scenarios as a group, and she asked them what they would do in that instance. She said staff were instructed to initiate 1 on 1 supervision following that type of incident and were to remain with the aggressive resident.	A 025		

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A 025	Continued From page 12 On . . . . at 5:20 pm, caregiver J said when the incident occurred between residents #1 and #2, she was not cleaning the dining room, she was in the wellness director's office discussing laundry. She said there were two caregivers in memory care, and she did not feel this was enough. She said she always does her best to keep the residents safe. She said it helped when she calmly approached and spoke kindly to resident #2. The facility's , neglect, and , policy, last revised . . . . , indicated an incident of resident-on-resident contact would result in the resident's assessment and service plan being updated as appropriate. A review of resident #2's service plan, initiated on . . . . . , revealed none of the focus areas had goals or interventions that pertained to the resident's behaviors. 2. A review of resident #11's record revealed a facility admission date of . . . The resident's medical history included . . . . . . On . . . . . at 7:31 pm nurse A documented the resident . . . . . throughout the memory care unit going in other resident rooms and sleeping in their bed. On that day the resident was easily redirected to his own room. On . . . . . at 4 pm nurse F documented the resident went in another resident's room and refused to leave when the resident asked him to. This resident took three of the resident's sodas out of the refrigerator. Despite staff redirecting this resident out of the room, he returned three more times. He began to get aggressive towards the staff.	A 025		

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A 025	Continued From page 13 On at 6:29 pm nurse F documented the resident in other resident rooms but was usually easy to redirect. On at 4:28 pm nurse F documented the resident had a tendency to into other resident rooms. On at 3:40 pm the wellness director documented the resident went into another resident's room (resident #1) during the 11pm-7am shift. Resident #1 told him to get out of her house then she walked to her door. Resident #11 followed the resident to the door then once he stepped outside of the room, he turned and punched resident #1 on her forehead, causing her to . Resident #1 did not sustain an injury. On at 2:35 pm the wellness director documented the resident's family was informed of the need for continued 1 on 1 supervision. On at 6:24 pm the wellness director documented the resident's 1 on 1 caregiver reported the resident hit him in the . On at 2:57 pm nurse F documented the resident was discharged to another facility. A review of the resident's service plan revealed interventions for his were initiated on and . 3. Resident #3's record review revealed admission date . The last 1823 Health Assessment dated listed medical history of Acute , , Failure with , , Left	A 025		

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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 ______	04/16/2024

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 025	Continued From page 14	A 025		

ankle , Lymphedema, , , Hyponatremia, , , and . He needed assistance with all activities of daily living (ADLs) in ambulating, bathing, , grooming, eating, toileting and transferring. His status was assistance with feeding, , hygiene, and toileting ( ). He needed assistance with self-administration of medications.

(Photographic Evidence Obtained)

A facility note dated at 9:21 AM by Nurse F documented resident #3 was alert with . He needs assistance with ADLs with toileting and showers totally. He was with / . Medications are given crushed without difficulty. Resident #3 uses a wheelchair for mobility and eats all his meals in the dining room. Resident #3 now on pureed diet with nectar thick liquids which is tolerated well. No behavior issues. No recent or trips to hospital.

A facility note dated ordered a , with 2 views. Diagnosis with / causing immobility.

On at 4:05 PM an attempted observation for resident #3 to transfer and pivot from wheelchair to the toilet for bathroom break. Furthermore, attempted to wave hello to resident #3 but he did not respond, , he did not even know someone was there. He was just peacefully sitting in his wheelchair in the dining room with his peers waiting for dinner meal to arrive.

On at 4:10 PM, an interview with

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A 025	Continued From page 15 Caregiver I and Unlicensed Caregiver K confirmed that resident #3 can no longer transfer himself or help with transferring from his wheelchair to the toilet. Resident #3 was totally dependent on 2 person assist totally with toileting and baths. The facility no longer gives him showers, gives him bed baths and he wear adult briefs for with and . There was no documented evidence that resident #3 will be evaluated and treated for Hospice care or no documentation if a 45-day notice for a higher level of care was issued. On at 4:20 PM, an interview with the Health Wellness Director and Administrator confirmed the findings. Class II	A 025		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the	A 026		

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A 026	Continued From page 16 facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a schedule of activities available for 6 days a week, 12 hours a week posted in a common area where residents normally congregate in the Memory Care unit of the assisted living facility as required. Findings: During an observation on at 2:03 PM, there was an empty bulletin board. There was no activity schedule posted. (Photographic Evidence Obtained) On at 2:05 PM, an interview with the Memory Care Activity Director confirmed the finding and further stated that she was only taught	A 026		

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A 026	Continued From page 17 to post the activity schedule on the weekends because she does not work on the weekends, and she was here during the week to have activities with the residents. An observation at 2:06 PM, about six residents were painting in the dining room in the Memory Care unit. On at 2:30 PM, an interview with the Administrator confirmed the finding. Class III	A 026		