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 _____	05/01/2024

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

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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		

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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 the facility review and interview, the facility failed to submit an adverse incident report electronically to the Agency within 1 business day after the occurrence of the incident and 15 calendar days after the occurrence of an incident for 1 of 2 sampled resident (#2). Findings: A record review of Resident #2 revealed a facility's admission date on . . . . . A 1823 Health Assessment Form indicated the resident who lives in the facility's secured memory care unit had a medical history of . . . . . and was at risk of . . . On . . . . . at 10:16am Unlicensed Caregiver A stated, "I was not here, but I heard about it. Resident #2 . in the bathroom. She was taken to the hospital, but she never returned and then I heard she , ... On . . . . . at 10:25am Unlicensed Caregiver C stated, "Yes, Resident #2 had a I believe the beginning of , . She went to the hospital then to rehab and , ... there."	CZ821		

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CZ821	Continued From page 4 A facility note on at 10:56 read, "resident #2 has a in her and is wearing a collar at the hospital." A facility note on at 17:43 read, "resident #2 occurred on 11:35, resident's bathroom, not shower/tub. was near the toilet. Resident stated that she was trying to go to bathroom. Residents' forehead was ." A facility note on at 15:30 read, "resident was admitted to the hospital for a in her ." On at 9:33am the Administrator stated, "Resident #2 was sent out to the hospital and , there. The Administrator stated Resident #2 had multiple at the hospital and rehab but did not at the facility." On at 3:34pm the Health and Wellness Director stated, " I did not submit an Adverse Incident Report for Resident #2's that sent her to the hospital. I followed up with the Administrator and she followed up with corporate. They informed her that she did not need too." On at 4:53pm the Administrator stated, "Resident #2 was not a risk and very independent. My corporate nurse stated there was nothing we could have done to prevent the . That's the reason we did not submit an adverse incident report. Your regulations state something different and you're not following your regulations." Unclassified	CZ821		

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A 000	Continued From page 5	A 000		
A 000	Initial Comments A complaint investigation #2024001771 was conducted at Brookdale Lake Mary on . The facility had deficiencies at the time of the survey.	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 agreed to by the facility and the resident,	A 010		

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A 010	Continued From page 6 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 notify the appropriate contact person in the	A 010		

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A 010	Continued From page 7 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, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 8 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. (g) Continued residency criteria for facilities	A 010		

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A 010	Continued From page 9 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 reviews and interviews, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 2 of 2 sampled residents (#1, #2) as required in an assisted living facility (ALF). Findings: 1. On [redacted] a review of incident report dated [redacted] revealed Resident #2 elopement. A record review of Resident #2 revealed a facility's admission date on [redacted]. A [redacted] 1823 Health Assessment Form indicated the resident who lives in the facility's secured memory care unit had a medical history of [redacted] and was not identified as an elopement risk. A facility note on [redacted] at 7:30 read, "Resident #2 was seen by staff member walking on Lake Mary Blvd towards the Winn Dixie [redacted], upon his arrival to work." On [redacted] at 3:34pm the Health and Wellness Director stated, "I did not obtain a new 1823 for Resident #2." 2. On [redacted] a review of an incident report dated [redacted] revealed Resident #1 elopement. A record review of Resident #1 revealed a	A 010		

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A 010	Continued From page 10 facility's admission date on . . . . . A 1823 Health Assessment Form indicated a medical history of . . . . . and was not identified as an elopement risk. A facility note on at 16:27 read, "alerted by receptionist that resident left the building and was across the street. Resident #1 was seen standing in a . . . . office talking to the . ." A facility note on at 11:53 read, "Resident #1 was seen by Skilled Nursing today for Resident to be admitted to hospice services." A facility note on at 20:42 read, "Resident #1 had psych assessment from advent health hospice." A review of Resident #1 record revealed an Integrated Plan of Care indicating a start date of Hospice Care on and Hospice Care Admission Date . . . . . . On . . . . . at 3:34pm the Health and Wellness Director stated, "Resident #1 was hospice before I came here, and he was placed on hospice due to his . . I requested the 1823 from the nurse who came to evaluate him when he was accepted on the services but did not follow up." On . . . . . at 4:53pm the Administrator stated, "Based on the date he eloped we put the sitter in place. The prior elopement from . a sitter was put in place and the psychiatrist stated he was better due to the change. The doctor changed his 1823 as no longer an elopement risk."	A 010		

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A 010	Continued From page 11 Class III	A 010		
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,	A 025		

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A 025	Continued From page 12 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 additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide adequate supervision to 1 of 1 sampled resident who eloped from the facility's secured memory care unit (#2); 1 of 1 sampled resident who eloped from facility's assisted living unit and failed to provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for and injuries for 1 of 1 sampled residents (#2). Findings: A record review of Resident #2 revealed a facility's admission date on . A 1823 Health Assessment Form indicated the resident who lives in the facility's	A 025		

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A 025	Continued From page 13 secured memory care unit had a medical history of , was at risk of , and was not identified as an elopement risk. A review of the facility's Elopement Policy states, "Any incident where a resident leaves the secured memory care area of the community or the secured courtyard, unescorted, with or without injury. Residents living in a designated 's and Care community, or unit shall be considered at risk for elopement." On a review of incident report dated revealed Resident #2 elopement. "On at approximately 0730 memory care resident, Resident #2 was seen by a staff member who was coming to work on Lake Mary Blvd in front of Dunkin Donuts. The staff member stopped and stayed with the resident while contacting a caregiver at the community to seek assistance. A visitor of another resident who resides in memory care had previously watched a staff member enter the code to access memory care. As soon as the visitor entered resident #2 exited the door before the maglocks could secure the door." A facility note on at 7:30 read, "Resident #2 was seen by staff member walking on Lake Mary Blvd towards the Winn Dixie , upon his arrival to work. The resident was not resistant and returned to the community with staff at approximately 7:40am. An investigation was conducted to determine how the resident was able to leave the community without supervision and it was found that a visitor had let her out." On at 10:16am Unlicensed Caregiver	A 025		

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	AL11965818	A. BUILDING: _____ B. WING _____	05/01/2024

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A 025	Continued From page 14 A stated, "Resident #2 normally did not hang by the door. Oh, I was here that day when Resident #2 got out, but I was upstairs. After she got out, we were reminded to make sure we hide the code as much as possible so that residents do not see it." On at 10:20am Unlicensed Caregiver B stated, "I was off that day when Resident #2 got out of Memory Care. Yes, she would hang by the door, and we're always told to make sure she doesn't get out or see us punching in the code. She would always say she's trying to get to her car or go home. I believe she asked another staff member if she could use their cell phone. Afterwards, the facility did the elopement drill and fire drill." On at 10:25am Unlicensed Caregiver C stated, "I was coming in the morning to work the day Resident #2 got out. When I was coming in to check everyone that's when I heard because 11 -7 shift was still here. Occasionally Resident #2 would say she wanted to get out. We sometimes take the residents out of memory care out on the front porch. For those that could walk we would walk them around the parking lot. After Resident #2 returned to the facility we had an elopement drill." On at 12:02pm Caregiver E stated, "the Maintenance Director was the staff who saw Resident #2 near the Dunkin Donut near the shopping plaza located to the right of the facility. Yes, I was working in Memory Care that day. Prior to that day resident #2 was pacing up and down. I saw her at 7am and then about 7:15 the Maintenance Director called to say he had seen her. He tried to bring her , but she wouldn't go with him. No, Resident #2 would not typically	A 025		

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A 025	Continued From page 15 hang out by the door. There was another resident family member in memory care visiting her grandfather. She put in the code to exit, and the resident must have been right behind her and left out." On [redacted] at 12:30pm the Maintenance Director stated, "Yes, I saw someone who looked like Resident #2 as I was coming to work around 6am to do a task. I was coming in early that day but typically I come in at 7am. I was driving and could not stop because I was on the other side of the street. So, I called the facility around 6am as I didn't have anyone's direct number. I told them to get in touch with memory care because it looked like Resident #2. No, I didn't stop or wait for anyone to arrive. I wasn't sure if it was resident #2 but her appearance made me think it was possible which is why I called the facility to have them check. No, it was definitely 6am not 7am." On [redacted] at 3:34pm The Health and Wellness Director stated, "the visitor of another resident in memory care comes in early to visit their family. The staff stated they just happened to see her in the building, but no one recalls letting her into memory care. It was not until the Maintenance Director called to let them know that he saw someone who looked like Resident #2. The staff called Unlicensed Caregiver E to tell me, and Unlicensed Caregiver F went to the Winn Dixie Plaza to look for the resident. Resident #2 got into the car with Unlicensed Caregiver F and returned to the facility. The visitor was still present and Unlicensed Caregiver E asked her and she stated that she did see Resident #2 go out the door and stated that was not her job to tell anyone. I asked Resident #2 what happened, and she replied I went for a walk to get coffee. No, Resident #2 does not go to the	A 025		

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A 025	Continued From page 16 door and stays in the common area. Yes, we take her outside of memory care to the porch or common areas outside of Assisted Living and she will come in." On at 4:53pm the Administrator stated, "a staff saw Resident #2, while driving in to work and saw her. Immediately contacted the caregivers and they went up to Dunkin Donuts area. She was unharmed and didn't get far. We changed the code, educated the staff, and placed signage to ensure the door is secured. Yes, I asked the visitor and she stated she saw a staff member enter the code, so she just used it to let herself in. She stated, yes, I saw Resident #2 leave out the door and that it was not her job to tell us." A review of the facility's sign in and sign out log for - did not reveal the visitor's name listed on the log. On at 10:16am Unlicensed Caregiver A stated, "I was not here, but I heard about it. Resident #2 in the bathroom. She was taken to the hospital, but she never returned and then I heard she , On at 10:25am Unlicensed Caregiver C stated, "Yes, Resident #2 had a I believe the beginning of , . She went to the hospital then to rehab and , there." A facility note on at 10:56 read, "resident #2 has a in her and is wearing a collar at the hospital." A facility note on at 17:43 read, "resident #2 occurred on 11:35, resident's bathroom, not shower/tub. was near the	A 025		

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A 025	Continued From page 17 toilet. Resident stated that she was trying to go to bathroom. Residents' forehead was ." A facility note on at 15:30 read, "resident #2 was admitted to the hospital for a in her ." A facility note on at 23:36 read, "resident #2 had a and hit her , she to hospital for observation." A facility note on 11:47 read, "resident #2 occurred on at 2:02am. Resident was trying to get up to go to the bathroom. There were signs of , as result of the , on her right ." 2. On a review of Adverse Incident Report #620155 dated revealed Resident #1 elopement. "At approximately 1445 the community front desk was notified by a rehabilitation business located across the street from the community that resident #1 had left our property and was sitting in their waiting area." A review of the facility's Elopement Policy states, " 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- and Care community who have a documented diagnosis of shall also be considered as risk for elopement." A record review of Resident #1 revealed a facility's admission date on . A	A 025		

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A 025	Continued From page 18 . . . . . 1823 Health Assessment Form indicated a medical history of and was not identified as an elopement risk. A facility note on . . . . . at 16:27 read, "writer was alerted by receptionist that resident left the building and was across the street. Resident #1 was seen standing in a , , office talking to the . . . , . . . Writer and Maintenance try to talk to resident, and he refused to leave once he saw the Brookdale bus. Resident stated he was not coming ." On at 11:05am Unlicensed Caregiver D stated, "I was not here the day Resident #1 got out. Resident #1 would get upset with his family and would say he wanted to get out of here. Most of the time he would say his family is taking advantage of him. He's only tried to leave the 2 times that I'm aware. Yes, we checked daily and documented in the computer when we passed meds that he had his ID bracelet on. Yes, he had it on . . . . when I did meds that day." On . . . . . at 12:02pm Unlicensed Caregiver E stated, "Resident #1 would walk out with his walker to the porch. I guess that day he kept walking, and we were all in the front lobby doing an activity. He was there in activity and then when we looked up. He was not on the porch. It was only a few minutes before we immediately got the bus and went to look for him. Someone called us and told us they saw a gentleman walking with a walker on Middle Street. We called the family because he needed a one-on-one sitter. If you don't keep your , on him, he will leave." On at 12:30pm the Maintenance Director stated, "I don't know why he was not on the premises. Resident #1 was right across the	A 025		

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A 025	Continued From page 19 street and seemed agitated, so I was asked to come and help. Yes, Resident #1 came with me to the facility. I was not aware Resident #1 was identified as an elopement risk." On at 3:34pm The Health and Wellness Director stated, "prior to elopement Resident #1 had walked around the parking lot that day and I would check outside. We had an activity around 1:30pm that day and he was sitting up front in the parlor area. I left to go upstairs, and the receptionist received a phone call stating he was across the street. I immediately came downstairs and ran across the street with Maintenance. Resident #1 did not want to leave from across the street with me but would leave with Maintenance. Prior to coming to the community, I was aware that he was an elopement. However, he was doing better with his meds, so I didn't see him attempting to leave. Yes, he was placed with a 24-hour sitter after returning to the facility." On at 4:53pm the Administrator stated, "Yes, we allowed Resident #1 to go about the facility. Based on the date he eloped we put the sitter in place. The prior elopement from , a sitter was put in place. The Psychiatrist stated he was better due to the change of his medication. The doctor changed his 1823 as no longer an elopement risk." (photographic evidence obtained) Class II	A 025		