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
	AL11965390	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST MELBOURNE	7199 GREENBORO DR WEST MELBOURNE, FL 32904

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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	CZ821		

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 record reviews and interviews, the facility failed to electronically submit to the agency a preliminary report within 1 business day of incident and a full report within 15 calendar days of the incident for 2 of 5 residents sampled. (#1 and 3)

Finding:

A review of resident #1" record review revealed she was admitted on . Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included , , and . She was at risk for . She walked independently. Supervise bathing and grooming. Independent with other ADL's. A review of the facility notes revealed on Friday at 5:30pm The resident in the dining room. She was transferred to the hospital where she was diagnosed with a right . The facility submitted a day one Adverse Incident Report to the agency on Monday . The facility failed to submit a full report within 15 days of the incident ( ). The report was withdrawn by the facility on .

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CZ821	Continued From page 4 A review of resident #3 record revealed she was admitted on . Her record contained an 1823 dated . . Her diagnoses included , , , , and , , . She was at risk for . She walked independently. A review of the hospital record dated . revealed resident #3 received 3 staples to her , . On at 1:30pm an interview with the administrator was conducted. She said on resident #3 and #1 bumped into each other in the dining room and they both . There was a resident who witnessed the , but no staff were present in the dining room at that time. Both residents were sent to the hospital, a higher level of care, with injuries. On . at 1:35pm the administrator confirmed the Adverse Incident Reports for residents #1 and #3 were not submitted to the Agency as required. Unclassified	CZ821		
A 000	Initial Comments A complaint #2024004916 investigation was conducted at Brookdale West Melbourne Assisted Living Facility. There were deficiencies identified at the time of the survey.	A 000		
A 036 SS=G	59A-36.007(10) . CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of	A 036		

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A 036	Continued From page 5 (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to provide services in a manner that reduces the risk of transmission of This failure could potentially affect all residents, staff, and visitors. Findings: On at 9:50am during a facility tour resident #8 was observed in the dining room with a visible red raised on her , , arms, and lower . She was scratching her skin with both . During an interview she said she itched all over. She continued to scratch throughout the interview.	A 036		

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A 036	Continued From page 6 At 10am resident #2 was observed in the activity room scratching her . . . by rubbing it on the of the chair she was seated in. She said she was very itchy all over. At 10:03am Staff (A) said everything was going good except the residents are scratching and very itchy. Some had treatment for . . . . . already. She said they were going to treat everyone but did not know when. At 10:05am resident #3 was observed scratching her and arms in the activity room. At 10:12am an interview with the Administrator was conducted. She said the scrapings for were inconclusive. She reported the cases to the Department of Health (DOH). She could not provide a line list at that time of when treatment was provided or to whom it was provided. At 10:30am Spoke with a representative of the DOH via telephone. She said she had been dealing with in the facility for a year. She had tried to contact the Wellness Director but was unable to speak to anyone. Last year when the outbreak began, she reviewed the state regulations with the facility staff including posted notification for family and visitors, excluding staff for 24 hours after treatment, contact precautions, environmental cleaning (carpet and drapes), and treating all residents and staff , , , , . She said these things were not done. The agency representative received the most recent line list emailed to the DOH representative by the facility. It was dated and faxed on . The first noted case of a . . was dated	A 036		

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A 036	Continued From page 7 At 10:45am an interview with the administrator was conducted. She confirmed there was no signage posted for visitors or family as recommended by the health department. She said the Wellness Director was new, but they were working on the information for the DOH. At 11:40am in an interview with staff B he said . . . . . treatment was pending for all residents. The , cream that was ordered had not arrived from the pharmacy. At 2pm Staff C assisted with observation of resident #3 she was observed with a red raised bumpy on her torso, arms, , and . Resident #9, 10, 11, 12, and 13 also presented with a red raised . Staff C said she went to the hospital and got treatment for . . . . . Her husband also had to be treated because he got the . At 3pm The Administrator said they had not completed a facility wide resident body check for the outbreak. She said the caregivers tell the nurses if the residents have skin issues. The nurses perform a skin assessment quarterly and document any abnormalities. Review of the Skin Observations Forms provided by the Administrator found: Resident #3 had a . . noted on . . . . Resident #13 the form provided was dated . . . . . - no . . documented. Resident #8 the form provided was dated . . . . . - a . . was documented. The area was not specified. Resident #2 the form provided was dated . . . . - no documented. Resident #14 the form provided was dated - no documented.	A 036		

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A 036	Continued From page 8 At 3:45pm an interview with staff D was conducted. She said she was treated with , cream and months ago. Three weeks ago she went to urgent care and received treatment again. She was treated with . and because she had the same very itchy again. A review of the facility Communicable Control Policy dated last reviewed on documented the community nurse leader or designee is responsible for monitoring on an ongoing basis to assist in the prevention, transmission, and mitigation of communicable and . At 4:10pm The administrator provided a list of residents who had been treated for a . Only 2 were treated for . Resident #11 had been treated since of 2023 for . Resident #3 was treated with , on and . She was treated with and . On at 4:15pm the Administrator confirmed there was an outbreak causing a red, raised, itchy . She said all residents and staff would be treated for and she would send all updated information regarding the outbreak and the treatment to the DOH. Class II	A 036		