

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965818	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER BROOKDALE LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 150 MIDDLE STREET LAKE MARY, FL 32746		
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A 000	Initial Comments A complaint investigation #2025000821 and generator monitoring 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, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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A 010	Continued From page 1 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 applicable department.	A 010			

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A 010	Continued From page 2 (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 record; and, 3. If the resident's condition fails to improve within	A 010			

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A 010	Continued From page 3 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 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 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 1 of 6 sampled residents (#1) as required in a assisted living facility (ALF). Findings: On _____ at 11:09 am during an interview, Resident #1's family member stated upon entering the memory care unit the day after the _____ I asked what was wrong with my mom and the other residents? She stated the staff replied, oh, the residents were yesterday. Resident #1's family member stated, mom is on hospice and I don't believe she should have received those _____. Aren't those considered life saving measures? I sent the information to the POA and contacted hospice. I left before the hospice nurse arrived. A record review of Resident #1 revealed a facility's admission date on _____. A 1823 Health Assessment Form, a resident who lives in memory care had a medical history of _____, _____ of _____, localized _____, generalized _____, and _____. There was no indication on the current 1823 Health Assessment Resident #1 was receiving nursing services. The Director of Nursing was asked regarding Resident #1's health assessment form and if any changes occurred removing her from hospice. On _____ at 5:10 pm, the Director of Nursing stated, yes, Resident #1 is on hospice.	A 010			

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A 010	Continued From page 5 No, nothing has changed in her care and she has not been to the hospital. She has always been on hospice. I get new forms every year for the residents. So, it has to be on each form if the resident is on hospice? The Director of Nursing was informed of the regulations which stated a new 1823 is required every 3 years after the initial assessment or after a significant change, whichever comes first. (photographic evidence obtained) Class III	A 010			
A 030 SS=D	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all	A 030			

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A 030	Continued From page 6 residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and . 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with	A 030			

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A 030	Continued From page 7 convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.	A 030			

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A 030	Continued From page 8 (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or arrangement of transportation to health care . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the	A 030		

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A 030	Continued From page 9 case of a resident who has been adjudicated mentally _____, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (I) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without _____, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, _____, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and, if applicable, _____, Rights Florida, where complaints may be lodged. The notice must state	A 030			

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A 030	Continued From page 10 that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the	A 030		

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A 030	Continued From page 11 facility failed to assist with obtaining access to adequate and appropriate health care in the performance of health care services for 3 of 6 sampled residents (#1, #4, #6). Findings: On a review of an incident report dated . The outcome stated any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advance directives. Brookdale with a third-party company, Novir, to provide a clinic to Brookdale Lake Mary residents. The first onsite clinic was held on and the second was held . Prior to the clinic being held a Brookdale associate reached out to the health care responsible party for each resident and received verbal consent for which the resident would receive. Brookdale Lake Mary determined certain residents may have received a which they did not previously consent to receive during the clinic held on . Novir administered the Covid, , and to Resident #1 to which they were not provided consent to give. Novir was provided a list which specific that the resident and/or responsible had consented to receiving. The nurse practitioner of Novir, utilized Novir computer system called Tracks and misread their system and provided the resident with the they were eligible to receive but had not provided consent. The nurse practitioner provided the names of the residents that she had on her system and asked the Health and Wellness Director (HWD) to bring the resident to her. The HWD got the resident requested and verified their identity. Brookdale did not have the HWD, or another associate assigned to verify the	A 030			

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STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE LAKE MARY

**150 MIDDLE STREET
LAKE MARY, FL 32746**

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A 030	Continued From page 12 consent that had already been provided and was trusting the third party to honor the consent Brookdale had provided. A record review of Resident #1 revealed a facility's admission date on , A 1823 Health Assessment Form, a resident who lives in memory care had a medical history of , of , localized , generalized , and , An Addendum to 1823 - Clarification of Orders dated in Resident #1's chart read, may we administer a annually? yes. A record from Novir for Resident #1 identified COVID, (), and (), date given , observation end time: 11:12. A review of Resident #1's Medication Observation Records (MORs) for read, vital sign checks two times a day for follow up for 3 days start date . A facility note on at 10:00 am read, care conference, present at conference, Administrator, Director of Nursing, Resident #1, Resident #1's POA, and Ombudsman Representative. Topic Discussed: clinic process and what was learned. A facility note on at 12:37 pm read, reached out to Resident #1's POA to schedule care plan meeting. A facility note on at 11:06 am read, resident was observed in her apartment with staff and her family. A facility note on at 8:39 pm read,	A 030		

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A 030	Continued From page 13 resident was observed in the dining room. A facility note on _____ at 19:31 pm read, resident was observed in the common area and she did not show any sign of _____ or discomfort. A facility note on _____ at 15:38 pm read, ED (Executive Director) spoke with Resident #1's POA to review the _____, COVID, _____ and _____ that Resident #1 received on that she or Resident #1 had not provided consent. A facility note on _____ at 14:28 pm read, POA notified writer and ask what _____ was given and that is when we found out that resident was given _____ that family did not consent to. Writer immediately went to ED regarding the issue. A facility note on _____ at 11:45 am read, (patient) seen by AH (Advent Health) Hospice SN (skilled nursing). A facility note on _____ at 8:39 am read, a new order received by Resident #1's nurse practitioner, nursing to take (_____) once daily for one week and please keep log. A facility note on _____ at 12:23 pm read, resident was at _____ clinic and was administered COVID, _____, and _____. On _____ at 10:00 am, the Ombudsman sent notification stating, we visited the facility on Tuesday because we received a call from a family member about _____. Resident received some _____ without permission from the POA. We had a conversation with the Administrator (ADM) and Director of Nursing (DON). Company	A 030		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965818	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2025
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A 030	Continued From page 14 hired a third party; the first time they went there was no problem. The second time the nurse who went to the facility just followed the list of which residents were eligible for without asking if the residents' representatives had given permission for the residents to receive the . . . 10 residents were affected. On . . . at 10:34 am, caregiver A stated, the clinic gave us a list of the families that are authorized to go get the . I'm not sure where the clinic gets the list from. Caregiver A identified Resident #1 stating, yes, she's on the list and her family authorized her to get the . The list did not state which . The clinic wrote down the names of the residents they needed for the . the day they arrived. I took Resident #1 to get the shots. I wasn't in memory care that day, but I helped take the residents to the 2nd floor. Resident #1's family wanted to see the list of . that she received. I provided the list, the . card to the family and they called hospice. Caregiver A reviewed the current census and identified additional residents who received . at the 2nd clinic held on . On . . . at 10:47 am, caregiver B stated, yes, I worked that day (referring to .). I think there was a list that was printed out. The Health and Wellness Director (HWD) gave us the list. The list provides the residents names only and that there to get the . It does not state the . they will receive. It's just a list of the residents' name and that they are to be given the . I don't recall if it had a date. The nurse arrived and set up for the clinic in the theater room. Some people were designated to stay in there and I think the HWD was in there most of the time. Resident #1's name was on the list from	A 030		

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A 030	Continued From page 15 what I can recall. On at 11:09 am during an interview in the foyer area of the facility. Resident #1's daughter who was visiting, stated upon entering the memory care unit the day after the the environment seemed dimmed. I noticed Resident #1 was in her wheelchair with a pillow behind her and she was slumped over, appearing lifeless. With Resident #1 being non-verbal she was unable to tell me what happened. I immediately called the staff and asked what was wrong with Resident #1 and the other residents. She stated the staff replied, oh, the residents were yesterday. Resident #1's daughter stated, I requested to speak with caregiver C to ask what happened as Resident #1 was not to be and no one contacted Resident #1's Power of Attorney (POA). She stated aren't those life saving measures and Resident #1 is on hospice. I told caregiver C; Resident #1 was only authorized to receive the shot. Resident #1's daughter stated, caregiver C replied stating, I've never seen anything like this before. They herded them like cattle to the 2nd floor. We only had a list with names. We didn't know what they were to receive. I requested to speak with the HWD, but she sent caregiver A to speak with me. After the HWD never came to speak with me I sent the information to my sister who is the POA and contacted hospice. On at 12:20 pm, Resident #4 was asked if she participated in the clinic held by the facility. Resident #4 stated, I don't remember if I received a shot. She stated my family takes care of that. Resident #4 then stated, yes, I do recall receiving a shot, but I don't know the name or how many.	A 030		

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A 030	Continued From page 16 A record review of Resident #4 revealed a facility's admission date on A 1823 Health Assessment Form, a resident who lives in memory care indicated a medical history of Tatsuo, ..., E-, deficiency, ..., and 's On a review of an incident report dated The outcome stated any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advance directives. Brookdale with a third-party company, Novir, to provide a clinic to Brookdale Lake Mary residents. The first onsite clinic was held on and the second was held Prior to the clinic being held a Brookdale associate reached out to the health care responsible party for each resident and received verbal consent for which the resident would receive. Brookdale Lake Mary determined certain residents may have received a which they did not previously consent to receive during the clinic held on Novir administered the to Resident #4 to which they were not provided consent to give. A record from Novir for Resident #4 identified COVID, ..., (. . . .) (. . . .), and High Dose date given There was no observation end time notated. A facility note on at 11:12 am read, resident observed in the common area propelling around the unit. Resident denies any or	A 030			

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A 030	Continued From page 17 discomfort. A facility note on _____ at 8:33 am read, resident was observed in the dining room and denies any _____. A facility note on _____ at 20:43 pm read, resident was observed in the common area and she denies any _____ or discomfort. A facility note on _____ at 15:35 pm read, ED (executive director) spoke with friend of POA to review the _____ that Resident #4 received on _____ that she or Resident #4 had not provided consent. ED explained the follow up procedure of checking for signs and symptoms out of resident baseline along with vitals being checked. A facility note on _____ at 17:42 pm read, resident was observed in memory care propelling down the hall. Resident denies any _____ or discomfort. A facility note on _____ at 14:40 pm read, resident was at _____ clinic and received COVID, _____, and _____. On _____ at 2:35 pm, Resident #4's POA stated during a phone call, the facility called to inform me that Resident #4 received the shot. I didn't have any concerns with her receiving the _____ I would like her to receive the 2nd dose. We did discuss individually of each _____, and I didn't authorize _____ I signed a form during admission, but it was just a general consent form. For the clinic, I believe they called me for verbal consent. The Administrator was asked to provide the list of	A 030		

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A 030	Continued From page 18 residents who participated in the clinic. On . at 12:43 pm, the Administrator and HWD entered the conference room with a list of names stating these are the residents who received the . After clarifying the information to determine if this was the original list. The Administrator stated, no, these are the residents who gave consent on the 15th. There was one list, and the 15th was the second clinic. The first clinic happened on the 13th of . The Administrator stated, what the nurse practitioner ended up doing was she looked at the system wrong and read eligibility wrong and did not look at consent. On . at 12:45 pm, the HWD stated, once the nurse practitioner arrived on , she provided the list of names to me. It was handwritten on a piece of paper. I just looked at it to get the residents per her request. No, I didn't review to determine consent because we already provided that information from the 1st clinic. The HWD stated, no, I didn't keep the list. It was just written on a piece of paper. On . at 12:55 pm, the Administrator returned to the conference room with what appeared to be a 2-page spreadsheet stating this is the document that has all the residents listed for both clinics. She stated there were 2 clinics, and . We provided the list of residents prior to the . clinic of the residents. We spoke with the families and residents to determine the . that were to be administered. Novir provided the tool to be used for documenting the residents for the and type. We entered the residents' information into their system.	A 030		

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A 030	Continued From page 19 On a review of an incident report dated . The outcome stated any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advance directives. Brookdale with a third-party company, Novir, to provide a clinic to Brookdale Lake Mary residents. The first onsite clinic was held on and the second was held . Prior to the clinic being held a Brookdale associate reached out to the health care responsible party for each resident and received verbal consent for which the resident would receive. Brookdale Lake Mary determined certain residents may have received a which they did not previously consent to receive during the clinic held on . Novir administered the COVID to Resident #6 to which they were not provided consent to give. A record review of Resident #6 revealed a facility's admission date on . A 1823 Health Assessment Form, a resident who lives in memory care indicated a medical history of small obstruction, and receiving hospice services. A record from Novir for Resident #6 identified COVID, , and High Dose date given , observation end time: 10:28. A facility note on at 11:11 am read, resident was observed in common area eating a snack. A facility note on at 8:35 am read, resident was observed in the dining room.	A 030		

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A 030	Continued From page 20 Resident show no sign of discomfort of , but they are near injection site is red and cool touch. A facility note on at 21:03 pm read, resident was observed in memory care. The writer checked resident arm after staff was getting her ready for bed and the injection site was red and cool to the touch. A facility note on at 15:00 pm read, ED spoke with Resident #6's daughter to review the , Covid that Resident #6 received on that she or Resident #6 had not provided consent. ED explained the follow up procedure of checking for signs or symptoms out of resident baseline along with vitals. A facility note on at 17:01 pm read, resident was observed in the living room watching tv. A facility note on at 13:59 pm read, Resident was at clinic and received COVID, and . On at 4:50 pm, during a phone interview Resident #6's family stated, Resident #6 just had the COVID that she was not approved for. The facility reached out to make me aware, but I'm not keen on the COVID . I hope she'll be ok from it. On at 3:21 pm, caregiver C stated, we received a list of residents that consisted of about 8 names. We took them 2 at a time upstairs to the theater room. We waited for 15 minutes or so for any side effects then we took the residents downstairs. As for Resident #1, yes, she was taken upstairs. The next day her family came in and noticed Resident #1 was not	A 030			

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A 030	Continued From page 21 herself. Everyone thought it was because of the shots. Resident #1's daughter told me she contacted hospice. She already knew Resident #1 had received the shots and wanted to know which shots were given after speaking with hospice. She said she only was aware of 1 shot. I told her we were only following the list provided by the HWD and would not have known if a resident was not supposed to receive a . On . at 3:30 pm, caregiver D stated, I was not here the day the residents received the shots. The daughter's were concerned for Resident #1 when they came to visit on , the Sunday after the clinic. Resident #1 had a preexisting and after the shower I laid her on the bed with assistance from her 2 daughters visiting. Resident #1's daughter asked if it was from the . I told her it was there before, and she already had an order. The Administrator was asked if an investigation was conducted as to how the incidents occurred and to provide a copy of the facility's grievance log. On . at 4:22 pm, the Administrator stated, I put the information in the adverse incident reports. The facility's report is an internal document of my investigation, and I cannot provide that. I can tell you what I've done, but I can't provide a copy. The investigation found that the associate who administered the read their Novir system and provided the of the eligibility for the residents and not consent. They were the names of the people that received that were not consented. Every single one that was . I reached out to them and their families and it's in the progress notes.	A 030		

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A 030	Continued From page 22 Review of the facility's Grievance Log revealed date of grievance Resident #1, clinic, no consent. Follow up Investigation on by Administrator and HDW, resolution - reviewed with ombudsman, facility schedule afterwards, how to prevent non consent in future, complainant notified On at 3:30 pm via phone exit, the Administrator and Area Director of Operations confirmed the findings and provided no additional information. (photographic evidence obtained) Class III	A 030		
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility	A 031		

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A 031	Continued From page 23 administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a	A 031		

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A 031	Continued From page 24 guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility when requested by residents or representatives, failed to coordinate with the third-party provider to facilitate the receipt of care and services provided to meet the resident's needs for 3 of 6 sampled residents (#1, #4, #6). Findings: A record review of Resident #1 revealed a facility's admission date on . A 1823 Health Assessment Form, a resident who lives in memory care had a medical history of . of , localized ., generalized ., and . An Addendum to 1823 - Clarification of Orders dated in Resident #1's chart read, may we administer a annually? yes. A record from Novir for Resident #1 identified COVID, (), and (), date given ., observation end time: 11:12. A facility note on at 10:00 am read, care conference, present at conference, Administrator, Director of Nursing, Resident #1, Resident #1's POA, and Ombudsman Representative. Topic Discussed: . clinic process and what was learned.	A 031		

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A 031	Continued From page 25 A facility note on _____ at 15:38 pm read, ED spoke with Resident #1's POA to review the _____, COVID, _____, and _____ that Resident #1 received on _____ that she or Resident #1 had not provided consent. A facility note on _____ at 12:23 pm read, resident was at _____ clinic and was administered COVID, _____, and _____. Review of the facility's _____ Grievance Log revealed date of grievance _____ Resident #1, _____ clinic, no consent. Follow up Investigation on _____ by Administrator and HDW, resolution - reviewed with ombudsman, facility schedule after math, how to prevent non consent in future, complainant notified _____. On _____ at 10:00 am, the Ombudsman sent notification stating, we visited the facility on Tuesday because we received a call from a family member about _____. Resident received some _____ without permission from the POA. We had a conversation with the Administrator (ADM) and Director of Nursing (DON). Company hired a third party; the first time they went there was no problem. The second time the nurse who went to the facility just followed the list of which _____ residents were eligible for without asking if the residents' representatives had given permission for the residents to receive the _____. 10 residents were affected. On _____ at 10:34 am, caregiver A stated, the clinic gave us a list of the families that are authorized to go get the _____. I'm not sure where the clinic gets the list from. Caregiver A identified Resident #1 stating, yes, she's on the list and her family authorized her to get the	A 031		

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A 031	Continued From page 26 The list did not state which . The clinic wrote down the names they needed for the . the day they arrived. On . at 10:47 am, caregiver B stated, yes, I worked that day (referring to). I think there was a list that was printed out. The Health and Wellness Director (HWD) gave us the list. The list provides the residents names only and that there to get the . It does not state the . they will receive. It's just a list of the residents' name and that they are to be given the . I don't recall if it had a date. The nurse arrived and set up for the clinic in the theater room. Some people were designated to stay in there and I think the HWD was in there most of the time. Resident 1's name was on the list from what I can recall. On . at 11:09 am during an interview in the foyer area of the facility. Resident #1's daughter who was visiting, stated upon entering the memory care unit the day after the the environment seemed dimmed. With Resident #1 being non-verbal she was unable to tell me what happened. I immediately called the staff and asked what was wrong with Resident #1 and the other residents. She stated the staff replied, oh, the residents were . yesterday. Resident #1's daughter stated, I requested to speak with caregiver C to ask what happened as Resident #1 was not to be . and no one contacted Resident #1's Power of Attorney (POA). I requested to speak with the HWD, but she sent caregiver A to speak with me. After the HWD never came to speak with me I sent the information to my sister who is the POA and contacted hospice. A record review of Resident #4 revealed a	A 031			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965818	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2025
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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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A 031	Continued From page 27 facility's admission date on [redacted] A 1823 Health Assessment Form, a resident who lives in memory care indicated a medical history of Tatsuo, [redacted], E- [redacted], deficiency, [redacted], and [redacted]'s [redacted]. On [redacted] at 12:20 pm, Resident #4 was asked if she participated in the [redacted] clinic held by the facility. Resident #4 stated, I don't remember if I received a shot. She stated my family takes care of that. Resident #4 then stated, yes, I do recall receiving a shot, but I don't know the name or how many. A [redacted] record from Novir for Resident #4 identified COVID, [redacted], [redacted] ([redacted]), and High Dose [redacted] date given [redacted]. There was no observation end time noted. On [redacted] at 2:35 pm, Resident #4's POA stated during a phone call, the facility called to inform me that Resident #4 received the shot. I didn't have any concerns with her receiving the [redacted]. I would like her to receive the 2nd dose. We did discuss individually of each [redacted], and I didn't authorize [redacted]. I signed a form during admission, but it was just a general consent form. For the clinic, I believe they called me for verbal consent. A facility note on [redacted] at 15:35 pm read, ED (executive director) spoke with friend of POA to review the [redacted] that Resident #4 received on [redacted] that she or Resident #4 had not provided consent. ED explained the follow up procedure of checking for signs and symptoms out of resident baseline along with	A 031		

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER BROOKDALE LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 150 MIDDLE STREET LAKE MARY, FL 32746		
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A 031	Continued From page 28 vitals being checked. A record review of Resident #6 revealed a facility's admission date on . A 1823 Health Assessment Form, a resident who lives in memory care indicated a medical history of . small obstruction, and receiving hospice services. A record from Novir for Resident #6 identified COVID, , and High Dose date given , observation end time: 10:28. On at 4:50 pm, during a phone interview Resident #6's family stated, Resident #6 just had the COVID that she was not approved for. The facility reached out to make me aware, but I'm not keen on the COVID . I hope she'll be ok from it. On at 12:43 pm, the Administrator and HWD entered the conference with a list of names stating these are the residents who received the . After clarifying the information to determine if this was the original list. The Administrator stated, no, these are the residents who gave consent on the 15th. There was one list, and the 15th was the second clinic. The first clinic happened on the 13th of . The Administrator stated, what the nurse practitioner ended up doing was she looked at the system wrong and read eligibility wrong and did not look at consent. On at 12:55 pm, the HWD stated, the list, once created was not updated or any changes after the , 1st clinic. They loaded the list into their system. Once they	A 031		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE LAKE MARY		STREET ADDRESS, CITY, STATE, ZIP CODE 150 MIDDLE STREET LAKE MARY, FL 32746		
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A 031	Continued From page 29 arrived on _____, they provided a list of names to me, handwriting everyone's names. It was handwritten on a piece of paper. I just looked at it to get the residents per her request. No, I didn't review to determine consent because we already provided that information from the 1st clinic. The HWD stated, no, I didn't keep the list. It was just written on a piece of paper. On _____ at 12:55 pm, the Administrator returned to the conference room with what appeared to be a 2-page spreadsheet stating this is the document that has all the residents listed for both clinics. She stated there were 2 clinics, _____ and _____. We provided the list of residents prior to the _____ clinic of the residents. We spoke with the families and residents to determine the _____ that were to be administered. Novir provided the tool to be used for documenting the residents for the _____ and type. We entered the residents' information into their system. On _____ at 3:21 pm, caregiver C stated, we received a list of residents that consisted of about 8 names. We took them 2 at a time upstairs to the theater room. We waited for 15 minutes or so for any side effects then we took the residents _____ downstairs. As for Resident #1, yes, she was taken upstairs. The next day her family came in and noticed Resident #1 was not herself. I told her we were only following the list provided by the HWD and would not have known if a resident was not supposed to receive a _____. On _____ at 3:47 pm the Third-Party Representative from Novir was contacted and a voice message was left for a call _____.	A 031		

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A 031	Continued From page 30 The Administrator was asked if an investigation was conducted as to how the incidents occurred and to provide a copy of the facility's grievance log. On _____ at 4:22 pm, the Administrator stated, I put all the information in the adverse incident reports. The investigation found that the associate who administered the _____ read their Novir system and provided the _____ of the eligibility for the residents and not consent. They were the names of the people that received _____ that were not consented. On _____ at 6:55 pm during a phone call, the Third-Party Representative stated, this was the 2nd clinic at Lake Mary. A follow up for the 2nd _____. The first clinic was held on _____. She stated the nurse practitioner conducted both clinics and had no issues with the first one. On the consent forms she took it as consent to all _____ and misinterpreted. The family members interpreted that the residents would only receive the _____ requested and gave verbal consent to the community staff. The community staff input the information into our Track _____ System. The facility contacted me on _____ because of the error that occurred on _____. Once I identified the error, I contacted the Administrator and HWD. The nurse practitioner was counseled and terminated. I determined this was not a widespread error and only happened at Brookdale. The families were given my number, and they contacted me. I explained the error. I only spoke with 2 families, identifying Resident #1 but I'm unable to recall the second family. She stated the _____ Consent, our tracking system only had a check and did not identify which _____ to be administered. The nurse did not look at the _____ names.	A 031			

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A 031	Continued From page 31 Review of the facility's effective date Coordination of Services with Third-Party Healthcare Providers/Agencies last revised states the HWD/designee is responsible for coordinating care that is ordered by the physician/healthcare provider and documenting this in the resident's service plan. Services should be provided at the request of the resident or resident's family/responsible party with a physician's/healthcare provider order, specifically for such skills or treatment as needed. The facility failed to follow their third-party policy by coordinating with the _____ clinic for the services requested by the residents or residents' responsible party for consent of _____ to be rendered. (photographic evidence obtained) Class III	A 031		