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
	AL11922279	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS OF EASTBROOKE	201 SUNSET DRIVE CASSELBERRY, FL 32707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint survey (2025000914) and a generator monitoring were conducted on at Gardens of Eastbrooke, Casselberry. A deficiency was found at the time of the visit.	A 000		
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	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the 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, interviews and observations, the facility failed to ensure a general awareness of the residents' whereabouts for 1 of 2 sampled elopement risk residents (#1). Findings: A review of resident#1's health assessment dated [redacted] confirmed a medical history of [redacted], [redacted] / collapse, [redacted], and [redacted] communication [redacted]. Resident#1 ambulates independently, no assistance with daily living, assistance with medications, is alert and forgetful. Resident#1 is	A 025		

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A 025	Continued From page 2 designated on the assessment as an elopement risk. In a review of the incident report dated at approximately 3pm on , the director of nursing was notified that resident#1 was missing from the facility. Once determined that resident#1 did not have authorization to leave the facility an immediate search was initiated of the building and surrounding premises. At 3:12 pm staff B, received a call from resident#1's responsible party, who informed her that the fire department had the resident and was safe. At 3:14pm the fire department contacted the facility, confirming the status of the resident, then a count was initiated. The resident was returned to the facility at 3:25pm by Law enforcement. Resident#1 was last observed at 1:30pm by staff, he was standing in the hallway of the facility. The Department of children and families were notified on . Resident#1 was assessed by the facility with a to the right . The resident stated that when the door from the locked unit to the reception area and exit closed, he grabbed the handle and held it until he could open it and walk through. He stated he wanted to go for a walk. During an investigation, it was found out at 1:30pm staff A entered the front lobby through the main hallway door, securing the door behind her. As the door closed and mechanism latched, resident#1 was standing on the other side of the door and grabbed the handle, turning it and preventing the mechanism inner workings from fully engaging. All staff education was initiated on on supervision of residents, elopement awareness to include ensuring all exit doors are secured after opening, and monitoring residents who may be within closed reach of an exit door. In a review of the facility's internal review	A 025		

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A 025	Continued From page 3 occurrence/incident dated : At approximately 1:30pm resident#1 was seen near the door leading into the front lobby. Staff A stated she secured the door behind her when she went through the exit door to the lobby. A review of the law enforcement report states on at approximately 1504 hrs. we arrived to assist another agency, the Seminole County Fire Department (SCFD). Upon arrival they stated an elderly male (resident#1) walked from the assisted living facility to the present address, approximately 2 miles away from the facility. SCFD medically evaluated the resident and stated he was medically good to return to the facility. Spoke to POA and she stated that he should not be walking alone and is supposed to be housed at the assisting living facility. The resident stated he left the facility by remembering the code of the exit door. The resident was transported to the facility. Staff at the facility stated they did not notice that the resident left the facility. In a review of the facility's elopement policy, it states: If a resident is not on authorized leave initiate search with all available staff members of the building and premises. If a resident is not located within 15 minutes, notify the administrator and Law enforcement and legal representative. Initiate extensive search of the surrounding area. As part of the resident elopement response, the facility must at a minimum have elopement risk resident have identification on their persons that include name, facility address, and telephone number. The facility must have photo identification of all risk residents on file that are accessible to all facility staff and law enforcement.	A 025		

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A 025	Continued From page 4 In a review of Staff B's (statement)- on at 3:12pm reads she received a call from resident#1's power of attorney, and she stated the fire department had found resident #1 approximately 2 miles away from the facility. She asked who she could speak to about this occurrence. Staff B stated she immediately contacted the administrator. She stated she printed out multiple census to have the staff and herself do the protocol elopement procedure and coordinating headcount of all residents. In a review of Staff C's (statement) reads on after lunch resident#1 kept asking me to open his bedroom door. After I changed him, he went outside into the courtyard. A short while later heard the nurse was looking for resident#1. I began to look throughout the facility for him and could not find the resident An interview on at 10:20am, Staff A stated she saw resident#1 in front of the main doors to lobby and he was just talking to some residents. She stated she was coming in from the assisted living area and closed the door behind her and made sure the door completely closed. She stated then she went to get papers in the business office, which is in the lobby, she did not see him get out of door. She stated after the investigation she found out the door was not secure. She stated now we have another door installed before you enter the lobby, and alarms were put on all exit doors. She stated also the locks were changed. She stated he was found by the fire department 2 miles away from the facility. In an interview on at11am, the director of nursing stated the day it happened the nurse practitioner was here doing his rounds and resident#1 was the last resident to be seen. She	A 025		

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A 025	Continued From page 5 stated the nurse practitioner looked around for the resident and couldn't find him. She stated the nurse practitioner told her that resident#1 was missing. She stated she could not remember what time that was. She stated she looked around the facility and his room, rest rooms, and closets. She stated staff then went and checked every room and called the administrator. She stated she then started the staff looking for him inside and outside the facility. She stated after a few minutes of searching maybe 10 minutes, a call came in from the POA and stated that she got a call from law enforcement that resident#1 was found 2 miles from the facility. She stated 10 minutes after that he was brought to the facility by law enforcement. She stated the POA came to the facility and the resident was assessed by the nurse reactionary to have a . An interview on at 11:35 Staff G stated resident#1 is sometimes exit seeking, is aggressive but is usually very happy to be here. She stated he is very , . She stated we do elopement drills almost monthly and go over the elopement policies. She stated all the residents wear plastic identifications on them and are considered an elopement risk. She stated we are very good at keeping an , on the residents. Supervision is very good on all shifts. She stated staffing is good and we are able to do our jobs and take good care of the residents. She stated she was not there the day the incident occurred. An interview on at 12pm Staff H stated I was not working the day resident #1 eloped. She stated I am aware of the occurrence. She stated we do a lot of elopement drills like once a month. She stated before each shift we do a count, and every exit door has a loud alarm that no one	A 025		

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A 025	Continued From page 6	A 025		

can hear. She stated that resident#1 can be aggressive and moves around a lot and if he gets the chance or the opportunity he will leave. She stated that when his power of attorney (POA) visits he wants to leave with her. She stated most times he is calm. Usually, we call the POA and that calms him down. She stated he didn't need his medications changed as he is usually calm. He is redirected easily and listens to staff. She stated he gets along with other residents and staff. She stated he likes to stay to himself most of the time. She stated staffing is very good and enough to care for the residents.

In an interview on at 12:10pm Staff C stated resident#1 was calm that day and was not exit seeking. He stated he wanted to go to his room, and I opened the door for him. He stated the nurse was looking for him and could not find him. He stated I then started looking for him. He stated after that management took over. He stated there are enough staff on my shift and weekends. He stated he had an identification on his , but he always takes it off. He stated after the elopement the identification was put on his ankle, so it is difficult to take it off.

In an interview on at 12:30pm Staff B stated "She doesn't know where she was at the time the resident left; she thinks she was in the . She stated the only reason she leaves the desk is to assist a family at the , but I am always stationed up front. She stated it has never happened before. She stated no one relieves her if she needs to leave the reception area and she does not always staff when she leaves the reception area. She stated she was not asked at the time of the facility investigation where she was when resident#1 left through the reception area and out the front doors. She stated the POA

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A 025	Continued From page 7 is the one who alerted the facility that he was missing from the facility and the fire department found him 2 miles away. She stated that the fire dept called and stated they wanted to know if we had resident#1 residing at the facility. She stated law enforcement brought the resident to the facility. She stated she has done elopement drills monthly." In an interview on at 2pm, family member and POA stated the fire dept found him and luckily he had my information on him. She stated the facility didn't even know he left. She stated he talks about being home, but he never leaves. She stated he thinks he is living in a hotel, so he is happy at the facility. She stated he is able to make his needs known but he does think he is going home soon, and he wants a part time job. She stated she comes 3x a week to visit and sometimes take him out for lunch. She stated he is very intuitive and figures things out. She stated since the incident the facility has installed double doors in the front now and alarms on all the exit doors. She stated she could not understand how the facility did not even know he was missing or how there was no one that saw him leave so that if I never called the facility, they would have never known he was missing. She stated he is not supposed to leave the facility unescorted. She stated he was very lucky he did not get injured and that he had my information on him for law enforcement to contact me. She stated she had never seen an identification bracelet on him before the incident. In an interview on 1:00pm Resident#1 stated he doesn't remember leaving the facility without family. He stated he likes living here, it is like a hotel but someday he will return home. Observed he was wearing an ID bracelet on his	A 025		

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A 025	Continued From page 8 ankle. He stated he has no complaints about the facility but wants to live with his family. He stated he likes the residents and staff. He stated they have a lot of activities, and he likes to participate in them. An observation on at 1:00pm of resident#1, he was wearing an ankle identification with name of facility, address and phone number. Resident#2, who is also an elopement risk was wearing an identification bracelet on his . An observation on at 1:15pm of the reception area and exit doors entering the assisted living area showed there are now 2 doors from the assisted living with locking mechanisms, before you enter the reception area to the front door. An observation throughout the day of the survey also showed that the receptionist leaves the area from time to time and no other staff replaces her or is alerted that she has left her area. Photographic evidence obtained Class II	A 025		