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 _____	02/25/2025

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

(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 investigation (2025001995 and 2025002107) and a generator monitoring was conducted at Brookdale Lake Mary on and . The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=D	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		

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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 review and interview, the facility failed to document in the record when 1 of 6 sampled residents was sent to a hospital (#10). Findings: Review of resident #10's record revealed a medical history of , type 2, , and , . On at 2:59 pm nurse G documented she was informed by the medication technician that the resident did not seem like himself, was more tired, had not been eating well but had been	A 025		

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A 025	Continued From page 2 noted picking food out of the trash. When asked, the resident denied complaints and voiced he was feeling ok. A health care provider was updated, and a request was made for an order for a . A hospital document indicated the resident's , was upon his arrival. His diagnoses at the hospital included likely , due to , acute , injury and 's . On the resident was discharged to a rehabilitation facility. There was no facility documentation in the resident's record to indicate he was sent to the hospital. On at 1:33 pm, the health and wellness director confirmed a note was not written. On at 1:13 pm, caregiver A said that on the resident did not eat much. The resident's family, one of whom brought soup for the resident, visited the facility. The resident told the family when they tried giving him the soup, "no, no, no" and pushed the family's away. The resident was wide awake and looking at the family members during the visit. The family instructed the staff to send the resident to the hospital. Class III	A 025		