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
	AL11964946	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MELBOURNE	1765 WEST HIBISCUS BLVD MELBOURNE, FL 32901

(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 (#2025003429) and generator monitoring were conducted at Brookdale Melbourne Assisted Living facility. There was a deficiency identified at the time of the survey.	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 observation, interview, and record review the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision for 1 of 6 sampled residents who sustained a with injury (#1). Findings: On resident #1 sustained a from her wheelchair while unattended on the facility bus. On during rounds resident #1 was observed seated in her wheelchair in an activity	A 025		

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A 025	Continued From page 2 on the memory care outside patio. She was calm with her , closed. She was not able to answer any questions about the due to status. On at 10:55am an interview with resident #1's daughter was conducted. She stated she visits her mother times a week. She said she met her mother at the doctor's office on . She had done that many times. The driver came and picked her mom up after the , , . The daughter stated her mother was the only resident on the bus. Later a nurse called her and said her mother was sent to the hospital because she on the bus. The resident's daughter stated she was not sure who the nurse was. A review of resident #1's record revealed she was admitted on . The resident lives in the memory care unit. The most recent health assessment in the record was dated . The resident's diagnoses included , and , . The resident was able to eat independently but required assistance with all other activities of daily living. A review of the facility notes found on at 3:30pm revealed the resident had a when the driver was attempting to get her off the bus. The resident returned to the facility on at 9 pm from the hospital with staples to the right side of her , . The stitches were on the right side of the . There was a to the resident's right upper arm, to the left middle and to thumb. Further review of her record found a Home Health note dated for care to her right arm and .	A 025		

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A 025	Continued From page 3 On at 11:15am an interview with the Administrator revealed resident #1 had been unbuckled from her wheelchair and the safety belts that secured her and the wheelchair in place. She was ready to get off the bus. The wheelchair ramp would not go down so the driver got off the bus to check why the ramp was not working. During the time the driver was off the bus, resident #1 sideways out of her chair. The driver then sat resident #1 up against the wall before going inside the facility to get the nurse. A tour of the bus was conducted with Driver C. There were belts bolted to the floor through metal tabs to secure a wheelchair. There was also a harness to secure the resident in the chair. The straps were clean and without fraying or loose parts. Driver C confirmed the straps were all in good order. On 25 at 12pm an interview with driver C was conducted. He said he had been the driver for 2 years. On the bus was parked at the entrance of the facility. Resident #1 was in her wheelchair. He unstrapped her and put her in a position to exit the bus on the electric ramp. He said the bus doors would not open, so he got off the bus to check why they were not functioning. He said he was off the bus for maybe 45 seconds. He realized the parking brake was not set, which causes the doors to remain closed. When he got on the bus resident #1 was on the floor on her side. He moved her because her was against the wall. He propped her up against the wall and exited the bus again and ran inside to get nurse D. Nurse D was in the nurse's office. She came out to the bus to check resident #1. Resident #1 had some from her	A 025		

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A 025	Continued From page 4 . Driver C stated he was not sure who called 911. They stayed with the resident #1 until paramedics arrived. Driver C confirmed there were no other staff or residents on the bus at the time resident #1 or when he left to inform nurse D. He said he did have a phone, but he was nervous because of the on the resident's #1 . On at 2:45pm an interview with Nurse D was conducted via telephone. She said driver C came to the nurse's office and told her resident #1 on the bus. She and two caregivers went outside to the bus. She said she did not want to move the resident because she was from her . She went inside to call 911. The caregivers stayed on the bus with resident #1. Nurse D said resident #1 was not prone to and she was surprised when she saw her on the floor of the bus. A review of the facility policy dated and titled Transporting Residents on Community Vehicles found under 1.b: All residents must be supervised and assisted by appropriate staff when onboarding and offboarding a community vehicle. At no time should a resident be left alone. On at 2pm an interview with the Administrator was conducted. She confirmed driver C did not follow the proper procedure. He should not have unbuckled resident #1 before having the lift ready. Driver C should not have sat her up after she was found on the floor. He should not have left her alone on the bus. He could have called the nurse or 911 and stayed with resident #1.	A 025		

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A 025	Continued From page 5 (Photo Evidence Obtained) Class II	A 025		