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 _____	04/29/2025

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
CZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each	CZ875		

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CZ875	Continued From page 1 employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information,	CZ875		

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CZ875	Continued From page 2 and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.	CZ875		

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CZ875	Continued From page 3 (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure 1 of 3 sampled caregivers completed a 1-hour training program on and Related (ADRD) within 30 days after beginning employment (B). Findings Review of caregiver B's record revealed a hire date of . The record did not contain documentation to indicate the caregiver completed a 1-hour training program on ADRD within 30 days of employment.	CZ875		

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CZ875	Continued From page 4 On at 12:23 PM, the business office manager stated, it's probably in the email and I'll go look for it. On at 12:32 PM, the administrator stated that the business office manager is calling to get a copy from the trainer. On at 1:02 PM, the administrator stated she's still on the phone and unable to provide a copy. Class III	CZ875		
A 000	Initial Comments A complaint investigation #2025004608 and generator monitoring was conducted at Gardens of Eastbrooke Assisted Living on - . The facility had deficiencies 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	A 025		

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A 025	Continued From page 5 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 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.	A 025		

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A 025	Continued From page 6 This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to provide adequate supervision to prevent resident-to-resident for 3 of 4 sampled residents (#1, #2, #6). Findings: Review of resident #1's record revealed a facility admission on . A 1823 health assessment indicated a medical history of , , , disturbance, disturbance, alert with and disoriented. An incident report dated read at approximately 8 PM, while sitting in the dining room watching a movie, another resident threw a chair across the room. The chair struck resident #1 causing her to to the floor. Staff were present in the dining room and immediately responded. Staff assessed the situation and observed on the top of resident #1's from the chair. Emergency services were contacted at approximately 8:05 PM. Emergency services, along with Casselberry Police Department, responded. At 12:05 AM, the director of nursing (DON) was informed that resident #1 would be returning to the facility and she received four staples to the . On at approximately 12:30 AM, resident #1 returned to the facility. A Casselberry Police Department report read on at approximately 20:09 hours, responded to Eastbrooke Gardens Residence Care, located at 201 N Sunset Dr. Upon arrival, officers met with several nurses and staff who	A 025		

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A 025	Continued From page 7	A 025		

were unable to explain what happened to law enforcement. After attempting to talk with several bystanders and the individuals involved, determined that all three individuals, identified by their names and date of births from nursing staff as resident #6, resident #2, and resident #1 suffered from . It was determined that resident #1 most likely suffered from a and everyone assumed a fight broke out.

A facility dated at 10:30 AM read on at approx. at 8 PM resident #1 was in the dining room sitting. The staff heard a commotion and ran to the resident from the other side of the room and noticed resident #1 had on the top of her . The medical doctor was called who gave orders for resident #1 to be sent to emergency room (ER) to be evaluated. Resident returned to facility on at around 12:30 AM.

A facility note dated at 6:30 PM read, staples were removed today.

A facility note dated at 5:59 PM read, psych ARNP ordered ABH gel. The resident was very agitated and continued to attempt to hit other residents as they walked by.

A facility note dated at 5:59 PM read, new orders received from Psych.

A facility dated at 4:42 PM read, behavior note resident has been very agitated. She has been picking fights with other residents. Staff must be constantly redirecting her.

On at 10:03 AM, resident #1 was observed sitting on a sofa near the C hallway asleep. The DON identified resident #1 by name

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A 025	Continued From page 8 and the resident looked up for a moment. On at 10:06 AM, resident #3 was asked if resident #2 ever hit him or if he recalls resident #2 throwing a chair hitting resident #1 in the . Resident #3 stated, I don't play that. They know not to bother me because I would have handled that. Resident #2 has never hit me. No, I didn't know anything about resident #2 throwing a chair at resident #1. If I did, I would have stopped it. No one called me because I try to keep things calm around here. On at 10:30 AM, resident #2's roommate stated he's a nice guy but sometimes he doesn't listen. He stated resident #2 sometimes tries to hit me but I stop him and will hit him . So, he doesn't try it too often. On at 11:18 AM, a second attempt was made to interview resident #1 who was still sitting on the sofa near the C hallway. Resident #1 was asked if she recalls being hit in the with a chair. Resident #1 looked up, grabbed the Agency for Health Care Administration (AHCA) surveyor's badge, not letting go and was unable to respond using clear, fluent words. Resident #1 appeared to be very . On at 11:20 AM, caregiver A stated resident #1 sleeps a lot, she speaks little English and may not be able to answer you. Review of resident #2's record revealed a facility admission on . A 1823 health assessment indicated a medical history of , , , , , and with behaviors. Review of resident #2's facility notes revealed no	A 025		

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A 025	Continued From page 9 documentation of the incident that occurred on . Resident #2 was asked if he recalls the incident where he threw a chair that hit resident #1. On at 11:25 AM, resident #2 stated yes, it was about a year ago. The resident was made aware that the incident happened last month. Resident #2 stated, no I have not hit anyone with a chair. The resident was asked if he had issues with any other residents hitting him or resident #6. Resident #2 stated no. He was then asked if he had any issues with his roommate. Resident #2 stated he's not my roommate. I just live in his house and have no issues or concerns with him. I just do what he tells me. On at 11:28 AM, the assistant director of nursing (ADON) stated, "I was not here when the incident happened between resident #1, #2, and #6. I heard about it when I returned to work on Monday. After that happened, we increased our staffing in the common area to more than 3 people to make sure we're able to better watch the residents. Resident #2 has never done anything like that before. I don't know if maybe he was sundowning, but we make sure to watch him more closely. On at 1:38 PM, caregiver C stated I filled out a report. I don't exactly recall what happened. We were sitting down in the dining room. I saw resident #6 push resident #2 on the floor. Caregiver B and I went to help resident #2 and calm down resident #6. Resident #1 was in the dining room. I didn't see resident #2 throw the chair. So, I really don't know. On at 1:48 PM, resident #1's family	A 025		

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A 025	Continued From page 10	A 025		

member stated via phone. Yes, I was told that resident #1 was hit by a chair. The facility told me it was a resident who showed no signs of this prior that he would have done something like that and he was not that type of resident. Resident #1 had to get 5 staples, and the cut was very deep.

The administrator was asked if an investigation was conducted, to provide any documentation, if possible, for review, and the facility's policy.

On at 2:08 PM, the administrator stated we did a facility investigation and reviewed the camera footage which is how we were able to determine the exact details of what happened. Unfortunately, I am unable to show you the footage as the camera only stays for 30 days. Resident #2 and resident #3 were just sitting there watching TV. Resident #6 was walking through the common area and resident #2 got up and threw his chair. It did not hit resident #6 and resident #1 was sitting nearby. The chair hit the resident 1 and she had to get staples. Yes, there were staff in the dining room, but in his case, there was no warning and everything happened so fast.

Review of documentation provided as the facility's investigation stated, timeline of events: Prior to 8 PM, resident #3 and resident #2 were sitting and talking in the dining room towards the front, in chairs next to each other. Resident #1 was sitting in a chair across from them. At the time of incident, two staff members were present in the dining room watching TV with the residents that were still awake. At approximately 8 PM, Resident #6 and another resident entered the dining room from the hallway. They proceeded to walk through the dining room.

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A 025	Continued From page 11 When they stopped in the center, resident #6 continued walking and proceeded to walk towards the front and as he passed resident #2 sitting in the chair. Resident #2 got up from his chair and picked up his chair and threw it. It happened to be the general direction that resident #6 was walking. The staff immediately ran over immediately to deescalate the situation. No staff were able to report exactly what happened. In the process, the chair hit resident #1 in the . During this resident #3 immediately went to resident #1 and comforted her. Staff noted that resident #3 had some on his shirt. It was then discovered that resident #1 was from her . 911 was called and she was sent out to Advent Health Altamonte. Review of the facility's undated prohibition, neglect & , states all health care facilities must immediately begin a thorough investigation of all incidents and document the findings for each incident. A thorough investigation may include: collecting and preserving physical and documentary evidence, interviewing alleged victim(s) and witness(es), interviewing accused individual(s) (includes staff) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source, collecting other information that corroborates the report of the incident or disproves it; and involving other regulatory authorities who may assist, e.g., local law enforcement, elder agency, Adult Protective Service agency. The immediate investigation will assist in determining whether an incident must be reported to DCF and AHCA immediately both, or neither. Report suspected, witnessed , neglect or , of a resident immediately.	A 025		

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A 025	Continued From page 12 The DON was asked about the documentation of the incident between the residents in their charts and the investigation conducted. On at 3:32 PM, the DON stated I didn't chart because when the staff called me, they told me resident #1 was _. So, I didn't chart anything on resident #2. Maybe I could have, but at that point what the staff told me wasn't clear. After our investigation it did identify resident #2 throwing the chair. Resident #2 just got up and threw the chair. He's never acted out before. He's one of our calmer residents. When it happened that night, there were only two staff in the dining room. Since that day we make sure the staff is rounding more. So, I guess I could have gone and updated resident #2 chart and resident #1's as well after we completed our investigation. On at 3:53 PM, caregiver B stated for the most part, I heard caregiver C scream and saw resident #6 push resident #2 to the floor. We ran to resident #6 to stop him from doing anything else to resident #2. Resident #2 was lying on the floor crying and resident #1 was lying on the floor crying. The administrator was asked if Department of Children and Families (DCF) was contacted based on their policy. On at 4:11 PM, the administrator stated I don't believe so in this case but let me check with our nursing consultant who does our reporting. On at 4:20 PM, the administrator stated it was not reported to DCF based on our policy. After the police came out and they didn't find anything we didn't feel it warrant reporting to	A 025		

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A 025	Continued From page 13 DCF. After we watched the camera footage, we didn't see resident #6 push resident #2. The statements provided by caregiver B and C didn't match what we saw so we didn't do any further investigation or interview the residents or staff. No, I didn't document any of that information stating that's what we did. I believe the incident happened over the weekend and by the time we came on Monday. There was no way the residents were going to remember what happened. On at 8:45 AM, the nursing consultant stated the incident will be submitted to DCF. On at 8:55 AM, caregiver D stated resident #2 has his moments when he's up and down, but he's usually fine. I was not here the day the incident happened, but I heard about it. Since then, we try to keep the residents more engaged with items and not so much with each other. I've never seen resident #2 in his agitated state, but he usually keeps to himself and stays in the same area. Resident #6 can get agitated too but I've never seen him in that state or in resident #2's . I was surprised when I heard that resident #6 had pushed resident #2. On at 9:18 AM, caregiver C stated there were about residents in the dining room and we were sitting with them watching a movie. I didn't exactly see where resident #6 was, but I did see resident #6 push resident #2. There was no drama before. I just saw resident #6 push resident #2 out of his chair. I went to help resident #6 and caregiver B went to help resident #2. Resident #1 was never on the floor and her chair was not turned over. I didn't see a chair by her. On at 9:41 AM, caregiver E stated I	A 025		

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	AL11922279	A. BUILDING: _____ B. WING _____	04/29/2025

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

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A 025	Continued From page 14 didn't witness the incident. Yes, I was on the schedule, but I was changing a resident with another staff. When I heard the screams, I went into the dining room and saw resident #6 standing and resident #2 sitting down in the chair. Resident #1 was sitting down in a chair crying. Review of resident #6's record revealed a facility admission on . A 1823 health assessment indicated a medical history of , 's, , and forgetful. Review of resident #6's facility notes revealed no documentation of the incident that occurred on . Resident #6 was asked about the incident and if he pushed resident #2. On at 9:52 AM, resident #6 stated I don't recall or have any recollection of the incident. Resident #6 stated I get along with all my co-workers at the job and I would never push anyone. No, I didn't see resident #2 throw a chair. On at 10:20 AM, resident #2's family member stated via phone. No, I was not aware of the incident when resident #2 threw a chair hitting resident #1. The last time he had an outburst they called me to try to calm him down. They didn't call me this time. His behavior has increased. He was having outbursts at home, so I had to move him into the facility. On at 10:38 AM, caregiver B stated we were sitting at a table near the 2nd TV in the dining room watching a movie with the residents. There were about 5 residents in the dining room. All I know is I saw resident #6 push resident #2	A 025		

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A 025	Continued From page 15	A 025		

down to the ground. I don't know what happened before that if resident #2 was standing or sitting in a chair. I don't know what happened to resident #1. I just saw her crying, hugging resident #3. So, I went to check on her and that's when I saw the . I'm not aware of any new preventative measures. No one has said anything to me about anything and I'm not aware of anything put in place since that happened.

The administrator was asked about the charting in the residents' records.

On at 11:48 AM, the administrator stated I don't typically chart in the residents' notes, that would be the DON. Typically, if they are not involved, we don't document. The administrator stated, "Let me check with the DON who can provide you with that information.

On at 11:55 AM, the DON stated, I didn't chart on resident #3 because he was just sitting. After completing the investigation, I should have gone and charted on resident #6. The staff wasn't sure of what happened, and their statements didn't match. The statement stated resident #6 pushed resident #2, but there was no evidence of that. The DON stated I was not aware that resident #2 and his roommate had an issue. I had not heard about resident #2 hitting him.

Review of the facility's undated accident prevention and safety awareness states any employee who is involved in or has knowledge of the reported incident/accident is to write a statement documenting what occurred, if a report concerns a resident, complete an incident report name of the person(s) involved and who they are: resident, employee, when charting only give an

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A 025	Continued From page 16 account of what happened in the incident, and all charting in the resident's record, on the incident report, any investigative report must all give the same account of the incident. The administrator was asked what preventive measures were put in place based on the incident and if any other staff on shift the day the incident occurred were interviewed. On at 3:55 PM, the administrator stated we did an all-staff in-service training and talked about resident rights & redirection, accurate reporting of incidents and proper notification. I told the staff to report what they see and not what they've heard from another resident or staff. No, I didn't interview anyone else who was working to find out if they witnessed anything. The administrator failed to follow their facility's policy by conducting a thorough investigation interviewing all residents and staff involved; failed to report to DCF at the time of the incident, and did not chart all resident's records who were identified in the incident. Resident #2 was not accessed after the incident to see if he needs a medication review or a higher level of care. (photographic evidence obtained) Class II	A 025		