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 _____	06/26/2025

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 #202500557 was conducted on at Brookdale Melbourne. The facility had a deficiency at the time of the visit.	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 resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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 interviews, the facility failed to provide care, and services appropriate to meet the needs of residents by failing to provide adequate supervision to prevent the elopement of resident #1. Findings: On at approximately 6:30pm employee A was notified by a concerned passerby who stated that a woman/resident #1 was walking along the side of the road. A review of resident #1 record revealed she was admitted on . Her record contained a	A 025		

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A 025	Continued From page 2 Resident Heath Assessment form (1823) dated . The resident had medical diagnoses as follows: Pacer, ,, , ,, and , , . Resident #1 ambulates independently. The resident was assessed to be alert and oriented times 1. On at 1:20pm employee A stated that resident #1 was not showing any type of change in behavior on the day the elopement occurred ( ). Employee A stated the last time she had seen resident #1 was in the dining room around 6:00pm. Resident #1 was seated in the dining room with some of the other residents. Employee A stated that she heard the doorbell to the facility ring at around 6:30pm. There was a lady at the door stating that she saw an older woman walking up the street and she was concerned because she looked a little . Employee A stated that a man was standing by the car pointing up the street stating that the woman who might be the resident was beginning to turn the corner. Employee A stated that she then walked outside and looked up the street but could not view the woman, but it was then when she walked out on to the sidewalk and looked, she noticed that the woman was resident #1 and she took off running. Upon reaching resident #1, employee A stated that she tried to bring the resident to the facility. Resident #1 was resistant to going to the facility however, employee A stated that after speaking with resident #1 she was able to get her to go to the facility. When resident #1 was inside the facility, employee A stated that she called the nurse (employee E), to let her know that resident #1 was in the building. Employee A stated that she then left so the nurse could do her assessment of resident 1.	A 025		

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A 025	Continued From page 3 At 1:47pm on Employee E stated that she was not aware of the elopement which occurred with resident #1. It was not until employee A called her to let her know that resident #1 had gotten out of the facility. When employee A called her and stated that resident #1 was in the building. Employee E stated that she immediately checked resident #1, from to , there was nothing to report other than she looked tired and seemed a little weak. Employee E stated that resident #1 was never one who exhibited exit seeking behaviors, so she was surprised that the resident got out and most of all who let her out of the facility. Employee E was asked how could resident #1 have gotten out of the facility? Employee E stated that resident #1 got out by someone who must have known the code to the front door. Employee E was asked if anyone sit at the front door to let family members in and out of the facility, she stated that there is a doorbell by the front door for the family to ring when they arrive for a visit. When the family members want to leave, they must notify the staff, and they will let them out. Employee E was asked how the family members are let out of the facility; she stated that employees must let the family members out and employees know not to give out the code to anyone. Employee E was then asked what the procedures are when a resident is known to be missing/eloped. Employee E stated that all employees must go room to room to get a count of all residents. The nurse in charge must notify the residents' family and call the administrator to let her know what is going on and how the situation is being handled. On at 3:15pm The administrator confirmed the facility did not follow their policy. The administrator confirmed the findings	A 025		

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A 025	Continued From page 4 Photographic evidence obtained. Class III	A 025		