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
	AL11964072	A. BUILDING: _____ B. WING _____	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST MELBOURNE	7300 GREENBORO DRIVE MELBOURNE, FL 32904

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A 000	Initial Comments A complaint investigation #2025012610 and generator monitoring were conducted on at Brookdale West Melbourne. There were deficiencies 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 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, interview and observation, the facility failed to ensure daily observation by designated staff of the activities of the resident while on the premises, physical and emotional well-being of the resident and maintain a general awareness of the resident's whereabouts for 1 of 3 sampled residents (#1). Findings: In a record review of resident#1's health assessment dated , revealed a medical history of , , , , , , stable but with continuing symptoms of , . Requires	A 025		

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A 025	Continued From page 2 24-hour , , care and an elopement risk. The resident was independent with activities of daily living and needed assistance with self-administration of medication. Review of the facility's observation notes of the incident revealed on at approximately 4:30 PM resident#1 was unaccounted for in a count during an offsite bus trip. Police were alerted and the search for the resident began. Resident #1 was found on at approximately PM by police. She was taken to the hospital and . Review of the internal incident report states revealed on several residents attended a shopping trip transported by the facility bus and escorted by the engagement director and bus driver. At 4:24PM during a count resident#1 could not be located. At 4:30PM a search began in the stores at the shopping center. At 5:08 PM law enforcement was called. The stores footage showed resident#1 walking by the store but not entering the store. At 6 PM the staff drove around the area. At 11:57 PM law enforcement found the resident's belongings at a dumpster behind the stores. On 1:20AM law enforcement began a search of the surrounding woods until 3AM. At 8:24 PM law enforcement alerted the facility that the resident was found in a park, disheveled and dirty but , she was transferred to the hospital where she was . Review of Law enforcement report: On , at approximately 1400 hours Detective responded to the area of the Melbourne Village Plaza in reference to a follow-up investigation into a missing person case. Upon arrival I was briefed on the circumstances of the	A 025		

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A 025	Continued From page 3 incident, in summary: On , Resident#1 went missing from the department store while out with a senior care group from the facility at approximately 1530 hours on . resident#1 told one of the chaperones for the senior group she needed to use the restroom. She went by herself, ostensibly to get a key to the restroom, but instead left the building all together. Resident#1 was discovered missing, and the chaperones tried to locate her in the store, before eventually calling the sheriff office at 1709 hours. Multiple officers and agencies conducted an extensive area check utilizing all available resources, to include multiple officers conducting patrols, hound tracks, and helicopter searches, at that time. He advised there had been an extensive track with his dog. He advised the track ended there due to the time delay, as well as the amount of and vehicle traffic in the intersection. While conducting an area check during the initial incident officers located video footage from the restaurant in the same plaza showing resident#1 traveling southbound on the sidewalk. She was identified by her clothing and distinct red walker she used to assist with her mobility. On , at approximately 1400 hours the detective responded to the area in reference to a follow-up investigation into a missing person case. At approximately 1930, the resident was located on an unrelated rescue call. Someone had called 911 to report a person lying on the ground in the park. This person was discovered to be the resident#1. She was wearing different clothes, which appeared to be her own clothing, and was found lying on top of a poncho like the one observed in the video from the rear of the department store. Resident's was tested and found to be normal, if slightly elevated. Resident#1 was transported to the hospital for	A 025		

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A 025	Continued From page 4	A 025		

medical assessment. Resident did not speak until she got close to the hospital when she made further comments about the , Donald Trump putting Tariffs on her personally and made other religious rambling. The resident's change of clothing, being within normal range, and recent , suggest this was a planned escape from her residence. Based on this information, the information obtained, and residents' concerning statements, she was placed under a by the officer. Resident was remanded to the custody of the Hospital.

In review of the facility's elopement policy, it states an elopement is considered when any incident where a resident leaves the interior of the assisted living portion of the community, unescorted or unsupervised, with or without injury, when it is determined she or she needs supervision.

In review of the bus driver's job description states driver will provides transportation to the residents for and errands, such as medical , banking, shopping, worship services, entertainment, and other activities. Ensures safety of all passengers. Running events and community errands as needed. Assists residents in wheelchairs if needed. Accounts for presence of all residents when leaving and returning to the community.

In an observation of the resident's signing in and out log in the front of the facility, it showed residents checked out but do not check in.

In an interview on at 10:30 AM with resident#4, she stated the facility is very lax in having residents to sign in out for residents or visitors. She stated she does not recall any staff

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A 025	Continued From page 5 checking on residents every 2 hours or doing wellness checks. In an interview on at 10:30 AM with staff A, she stated she took 7 residents to the department store along with the activity director. She stated the activity director was taking care of the resident in the wheelchair and she was responsible for the other 6 residents. She stated she let the residents roam the store while she stayed in the front of the store inside. She stated 5 residents came to her and stated they wanted to go to another store in the strip mall. She stated she then noticed resident#1 was not present. She stated she informed the other residents to wait inside in the front as she went to look for resident#1. She stated she checked the store and the bathrooms and resident #1 could not be found. She stated she thought that resident#1 might be in the next store, so she took the other residents and went to the dollar store 4 doors down. She stated she searched another store as well and she was not there. She stated she then called the administrator, and he immediately came to the stores. She stated we then went to look at the cameras in the first store, and it showed resident#1 entering the store but not leaving. She stated she then went to search the facility van and found resident#1's phone and wallet on the seat. She stated the administrator immediately called the police. In an interview on at 11 AM with staff B, she stated on that outing she was assigned to take care of the resident in the wheelchair and staff A was to watch the other 6 residents. When staff A realized resident#1 was missing, she searched all the stores in the strip mall and then called the administrator who then called the police. She stated the resident was found 1 day	A 025		

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A 025	Continued From page 6	A 025		

later approximately 2 ½ miles from the strip mall from where we were at. She stated resident #1 never did anything like this before. She explained resident#1 was very independent and even takes cabs on her own for transportation. She stated resident#1 was very happy that day and showed no signs of behavior issues or wanting to elope.

In an interview on at 12PM with staff C, she stated the resident was found a day later and she was not she was found sleeping. She stated emergency services took her sugar level at the time they found her, and she was fine. She stated the police her because she was having a break. She stated she did not return to the facility after being in the hospital and she resides somewhere else now. She stated resident#1 never showed signs of behavior, or exit seeking behaviors and has lived here for years. She stated she often went on outings and never had a problem. She stated she does not know what happened that day that made her off like that. She stated resident#1's 1823 was not audited until after the incident in . She stated we did not realize she was an elopement risk at the time or that she needed care before we audited the chart. She stated they only audit the 1823 yearly. She stated they audit resident charts every 3 months however the1823 is not audited at those times.

In an interview on at 1PM, resident#1's guardian stated the facility was aware she was an elopement risk at the time of admission and as she has attempted to run off from other facility's many times. He stated he was not aware that 24-hour care was on the assessment at admission but feels she needs constant supervision and more restrictive rules on her

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A 025	Continued From page 7 leaving the facility unescorted. He stated when she was admitted to the facility there were no restrictions on her at all, and she came and went as she pleased. He stated he was glad there were no serious injuries after this incident. He stated she is no longer residing at the facility as the resident was not supervised as she should have been. On 12:15 PM an interview with the wellness director, she confirmed the above findings. Photographic evidence was obtained Class II	A 025		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power.	A 200		

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A 200	Continued From page 8 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the	A 200		

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A 200	Continued From page 9 event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel	A 200		

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A 200	Continued From page 10 storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications,	A 200		

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A 200	Continued From page 11 alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule.	A 200		

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A 200	Continued From page 12 (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that	A 200		

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A 200	Continued From page 13	A 200		

makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request.
(c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law.
(6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines.
(7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.
(a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule.
(b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan.
(8) NOTIFICATION.
(a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's

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
	AL11964072	A. BUILDING: _____ B. WING _____	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST MELBOURNE	7300 GREENBORO DRIVE MELBOURNE, FL 32904

(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 200	Continued From page 14 legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain an operable alternative power source as required at all times when the assisted living facility is occupied pursuant to Chapter 252, F, S. Findings: A request was made on to observe the alternative power source on the premises, to ensure it is operable and in working condition. The unit was not operable. In an interview on at 10:15am with staff D, he stated the generator is not operable as it	A 200		

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
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A 200	Continued From page 15 has a defective regulator and low voltage. He stated the parts were on order, however he was not sure when they would be receiving the parts at this time. Class III	A 200		