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 _____	11/04/2025

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

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A 000	Initial Comments A complaint investigation #2025014166 and generator monitoring were conducted on at Brookdale Melbourne Assisted Living Facility. There were deficiencies 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, interviews, and record reviews, the facility failed to provide adequate supervision and care, and services appropriate to meet the needs of 2 of 6 residents sampled by failing to respond to resident #1 during a medical emergency. The facility failed to ensure safety through proactive measures to minimize the potential for and injuries for resident #6 who experienced repeated with injuries. Findings: 1. On at 1:30 PM, Resident #1 was observed on the patio. An interview was	A 025		

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A 025	Continued From page 2	A 025		

conducted. Resident #1 said on he was experiencing some difficulty breathing. He pressed his call button, but no one came. He said he waited about half an hour and no one came. He went on to say he called 911 from his cell phone and he had to go to the front of the building and let the paramedics in. He confirmed he held the time release bar on the entrance door and the alarm started going off when the door opened. Still no staff responded. The paramedics put him on the stretcher quickly and transported him to the hospital.

A review of resident #1s record revealed he was admitted on . His file contained a Resident Health Assessment form (1823) dated (post hospitalization). His diagnoses included , , and . The resident requires supervision with activities of daily living.

A review of the internal facility investigation provided by the Administrator revealed the following:
Resident #1 rang his call pendant on at 4:37 AM. Paramedics rang the front doorbell at 5:01 AM. No staff was present and resident #1 opened the door by pushing the delay bar for 15 seconds until the door opened. This caused the door alarm to sound.

The Administrator interviewed the staff assigned to resident #1 and documented caregiver D told her she was in the room by the medication cart. The Administrator also documented caregiver D confirmed she may have asleep. Further review of the Administrators investigation found caregiver D also confirmed the front door alarm was sounding and she turned it off when she

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A 025	Continued From page 3 woke up between 5 and 5:30 AM. She did not report anything to the oncoming shift. The internal investigation read Caregiver G, who worked 7 AM-3 PM on , was alerted to resident #1 being out of the facility when she received a call from the hospital requesting paperwork for resident #1. A review of the facility policy titled Resident Call System and Door Alarm Response dated last revised read, Associates should respond to resident call system alerts and door alarms in a reasonable and timely manner. Under C1 the policy reads When a door alarm sounds, associates should respond immediately. On at 12:10 PM, an interview with Administrator was conducted. She said Caregiver D was asleep in the activity room when resident #1 pushed his call pendant because he was experiencing . She explained the pendants send a message to the pagers carried by the caregivers. She confirmed resident #1 had to go to the front door to let the paramedics in because there were no staff responding. She confirmed the front door did alarm when resident #1 pushed the exit bar for 15 seconds. Still, none of the 3 staff in the facility responded. The Administrator confirmed the 2 staff working in the memory care unit could not hear the door alarm and they did not receive a call alert to their pagers for resident #1 because he was not in their assignment. The Administrator confirmed that caregiver D had a prior disciplinary action related to sleeping. She denied the allegation the first time, but the Administrator said she confessed to sleeping the second time.	A 025		

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A 025	Continued From page 4 2. A review of resident #6's record revealed an admission date of . Resident #6 had a medical history of and , , . Resident #6 Health Assessment form 1823 dated revealed she was a risk. Resident #6 lived in the memory care unit. On at 6:30 PM, in the progress notes written by Licensed Practical Nurse (LPN B), LPN- B wrote resident #6 had a . Resident could not move all her extremities; she was sent out to the hospital. On at 7:22PM, it was documented by LPN-E the resident #6 returned from the hospital. On at 12:00 AM, LPN-B wrote resident #6 was found lying down next to her bed. The resident was in her night clothes; the resident was bare and could not recall what happened. Staff assisted resident #6 to the bathroom where it revealed she had on her right , resident #6 denied , from the . Resident #6 was able to move all extremities. Resident #6 was not sent out for a higher level of care. On at 1:08 PM, the Administrator documented that resident #6's daughter called to request that her mother get an for her , and because the resident seemed to be getting worse with her , . On at 9:00 AM, LPN-B documented that resident #6 had witnessed a in her room near the bed. No physical signs of injury. The resident was not sent out for a higher level of care. On at 3:16 PM, it was documented by	A 025		

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A 025	Continued From page 5 LPN E that resident #6 was ambulating without any signs or symptoms of , . On at 3:00 PM, it was documented by LPN B that resident #6 had an unwitnessed in her room. There were no physical signs of injury. Resident #6 stated to LPN B that she was in , . LPN B documented that resident #6 stated "I'm in , , I have , ". LPN B documented that there were no signs of skin injury as a result of the . LPN B documented that resident #6 was able to move all extremities. LPN B documented that the physician was notified and her daughter was also notified. LPN B also documented that emergency services were not contacted. LPN B documented that the resident was fully dressed and she had on nonskid socks. LPN B documented that facility staff got the resident to her , and the resident did complain of , staff also noted that resident #6 was non- to her right . Primary care physician ordered a STAT X-ray of her right and ankle for a injury. On at 2:30 PM, resident #6's daughter requested that her mother be sent out to the hospital to be checked out. On at 10:00 PM, it was documented that resident #6 returned from the hospital. On at 9:10 AM, it was documented that the physician ordered resident #6 to have an , done to . On an was ordered on resident #6's right lower extremity on the same day the primary care physician ordered resident 6 to be transferred to the hospital due to a positive , ( ) right lower extremity.	A 025		

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A 025	Continued From page 6 On at 2:32 PM, the facility nurse spoke with the resident's daughter who informed her that resident #6 was going to have surgery on her right , due to a . On at 1:00 PM, in an interview with the administrator she stated that resident #6 is no longer at the facility due to her with injury. The that occurred on caused her to have surgery on her right , . The resident is currently still in the rehabilitation center. A review of the facility's Policy stated that upon admission each resident will undergo a assessment. The policy also goes on to say that per state regulations each resident will be evaluated at the time of move in. The evaluation also stated that when each resident an individualized intervention is considered. A review of resident #6 evaluation dated upon admission, documented her as a level 2 risk. Resident #6 had a post assessments dated and that indicated the staff will increase the frequency of monitoring of resident #6 and follow up on her , management. On at 5:07 PM, during an interview with the administrator, she was unable to provide documentation of the resident specific mitigating interventions for resident #6. The administrator stated that she is willing to try all channels to prevent residents from falling and whatever interventions the staff can implement with , , , , and reminding the residents to wear proper footwear as well as using their call pendant. On at 4:30 PM, resident #6's daughter did confirm that her mother had several at	A 025		

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A 025	Continued From page 7 the facility. The daughter also stated that on was the reason her mother had to have , surgery due to the . Resident #6's daughter stated that when she had asked the facility to send her mother out to the hospital on the hospital did not conduct any , , or scan of her lower extremities, instead the physician ordered an , of her to check for , . Resident #6's daughter stated the resident , , on . The facility failed to document and implement specific resident interventions to mitigate her . (Photographic Evidence Obtained) Class II	A 025		