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
	AL11965474	A. BUILDING: _____ B. WING _____	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEKIWA SPRINGS	203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703

(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
ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ⌄ , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on review of the facility's background screening clearinghouse and interviews, the facility failed to report the initial employment status within 5 business days for 1 of 6 sampled staff (E). Findings: On at 11:30 AM, review of the facility's background roster revealed Caregiver E, later identified as a licensed practical nurse (LPN) was not listed as an employee. On at 1:53 PM, the Health and Wellness Director stated LPN E has not worked here for a while. Adding, she was a borrowed employee from another Brookdale. On at 9:28 AM, the Business Office Coordinator stated LPN E is no longer picking up shifts here and was not added to the background	ZZ814		

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ZZ814	Continued From page 2 roster. On at 3:08 PM, LPN E stated she primarily works at Brookdale Lake Mary which is where she was hired but completed her training at Brookdale Wekiwa Springs. (photographic evidence obtained) Unclassified	ZZ814		
ZZ816 SS=D	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's to the Federal Bureau of Investigation for a national criminal history record check unless the person's are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the to the Federal Bureau of Investigation for a national criminal history record	ZZ816		

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ZZ816	Continued From page 3 check. The ␣ , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ␣ , . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying	ZZ816		

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ZZ816	Continued From page 4 offenses while employed by the employer. 59A-35.090 Background Screening. (d) Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the	ZZ816		

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ZZ816	Continued From page 5 Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to obtain a signed background screening compliance attestation for 2 of 6 sampled staff (E, F). Findings: On at 9:28 AM, the Business Office Coordinator was asked to provide the employee files for LPN E and Caregiver F. On at 10:00 AM, the Business Office Coordinator stated she was working with the HWD at Brookdale Lake Mary to fax LPN E's employee file for review. Adding, LPN E no longer is picking up shifts here and she did not obtain her file. Review of Caregiver staff F's record review revealed hire date on . There was no evidence documented of a signed background screening compliance attestation. On at 10:28 AM, the Business Office Coordinator confirmed she did not have the documents for LPN E and Caregiver F. Unclassified	ZZ816		
A 000	Initial Comments A complaint investigation #2025015864 and generator monitoring was conducted at Brookdale	A 000		

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A 000	Continued From page 6 Wekiwa Springs on /2025. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident	A 010		

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A 010	Continued From page 7 must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an	A 010		

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A 010	Continued From page 8 assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged	A 010		

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A 010	Continued From page 9 from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the	A 010		

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A 010	Continued From page 10 facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency for 1 of 4 sampled residents (#1) as required in an assisted living facility (ALF). Findings: Review of resident #1's record revealed a facility's admission on . A 1823 health assessment did not identify the resident as a risk. A facility note on at 8:37 PM read, day #3 re admit, resident alert and oriented. A facility note on at 5:32 PM read, day #2 re admission, resident alert with . A facility note on at 8:20 PM read, day #1 return to facility, resident alert and oriented and able to make needs known, denies , or discomfort. A facility note on at 6:08 PM read, resident arrived at the facility at approximately 4:45 PM, noted to be ambulating with the use of her wheelchair. A facility note on at 1:05 PM read, power of attorney (POA) stated resident will be getting discharged to facility from Apopka Rehab. A facility note on at 1:11 PM read, resident near dining, stated, I hit my on the floor, sent to ER for evaluation. A facility note on at 11:20 PM read, resident occurred on 11:20am - dining room, was near no furniture.	A 010		

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A 010	Continued From page 11 On at 4:06 PM, the Health and Wellness Director stated she did the assessment on resident #1's return from rehabilitation center. Adding, she did not know why resident #1 was sent to rehabilitation center and did not know she was a resident at the facility. She explained upon the assessment she noticed her gait was unsteady, so she ordered , , and , . The Wellness Director stated she was unaware resident #1 was a risk and believed the current 1823 was valid. On at 11:45 AM, the Administrator, Health and Wellness Director, and Health and Wellness Coordinator confirmed the findings. (photographic evidence obtained) Class III	A 010		
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	A 025		

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A 025	Continued From page 12 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 13 This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 1 of 3 sampled residents (#1). Findings: Review of resident #1's record revealed a facility admission on . A 1823 health assessment indicated a medical history of , , no physical limitations and was not identified as a risk. Her activities of daily living (ADLs) indicated she needed supervision with ambulation, toileting, and transferring. An incident report dated stated the resident is an assist x 1 with transfers and cannot self-ambulate. The apparent cause was that the resident attempted to stand up unassisted and due to her unsteady gait, the resident when attempting to self-ambulate. The facility's Management Policy last revised stated, Residents who sustained a should have a post evaluation to consider-possible interventions reduce the potential for future and injury. The service plan is reviewed for potential interventions and updated as necessary. are tracked and trended as a clinical indicator for quality improvement opportunities. An Orlando Health report dated stated a female delivered to our facility as a alert after a out of her wheelchair	A 025		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEKIWA SPRINGS	203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703

(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 025	Continued From page 14 today after hitting a curb. Emergency Medical Services noted periorbital and to the forehead upon their arrival. Patient arrived with C-collar, on board, evaluated as a Glasgow Scale 12. She was hypertensive with Spontaneous in 200s. for post prophylaxis. A facility note on at 2:49 PM read, resident Power of Attorney advised that resident was out of , and the next step is rehab/skilled nursing. A facility note on at 7:00 PM read, at approx. 5:35 PM, resident was found outside on the sidewalk. It was noted that the resident was lying on the ground on her right-side wearing shoes, her wheelchair was off the sidewalk beside her. The resident was unable to speak and had a substance coming from her . The resident's right was and closed shut. Prior to the at approx. 5:26 PM, the resident was seen eating dinner in the main dining room. The resident left the dinner table and was trying to go outside but was redirected to her meal. At approx. 5:30 PM, the resident was seen going outside and at 5:32 PM a resident sitting in the dining room called out for help stating a resident had outside. A facility note on at 6:26 PM read, resident occurred on at 5:35 PM outside the front door witnessed by a non-Brookdale associate. On at 2:10 PM, resident #4, a non-Brookdale associate who resides in the independent living community stated she was	A 025		

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A 025	Continued From page 15 sitting in a chair facing the window looking outside of the dining room. She stated resident #1's wheelchair looked like it was on the street just suddenly tipped over on the ground. Adding, she did not see her hit the ground, but the resident did not move afterwards. Furthermore, she rose from her seat and began calling for assistance to go outside. On at 3:45 PM Caregiver C stated resident #1 can't really walk on her own. I knew she was a risk. I took her to the dining room that day and sat her at the table. I went to the kitchen to give them the menus for the residents upstairs. When I returned to the dining room, I saw resident #1 trying to go outside so I redirected her to the table. Resident #1 stated she didn't want to eat and wanted to go sit outside. Caregiver C stated, she pushed the resident in her wheelchair outside and left her near the front door. Adding, she did not lock the brakes on the wheelchair because it's a Brookdale policy that they're not allowed to. Further stated, it's a if the residents want to move and are unable to. A facility note on 8:37 PM read, day #3 re admit, resident alert and responsive A facility note on at 5:32 PM read, re admission; resident alert with , assisted with ADLs. On at 4:06 PM, the Health and Wellness Director stated she did an assessment on resident #1 to return to the facility. Adding, she did not know why resident #1 went out nor did she know she was a resident of the facility. Further stating, was the first resident #1 had since she started in her position at the	A 025		

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A 025	Continued From page 16 facility. The HWD stated she was unaware of the prior and that resident #1 was a risk. Adding the policy states the facility is not allowed to lock the wheelchair as it is considered a . Review of the facility's Mobility Assistive Device states communities are responsible for ensuring the safe usage of resident's mobility assistive devices. Mobility devices consist of wheelchairs for residents with mobility challenges, walkers to assist with balance, and canes that provide support and stability while walking. A facility note on at 8:20 PM read, day #1 return to facility: resident alert and oriented and able to make needs known. Resident ambulates using her wheelchair to main dining room. A facility note on at 6:18 PM read, resident arrived at the facility at approx. 4:45pm, noted to be ambulating with the use of her wheelchair. A facility note on at 1:05 PM read, POA stated resident will be getting discharged to facility from Apopka Rehab. A facility note on at 1:11 PM read, resident near dining, stated, she hit her on the floor, sent to ER for evaluation. A facility note on at 11:20 AM read, Resident occurred on 11:20 AM - dining room, was near no furniture. Resident stated she was trying to walk and she hit her . On at 2:00 PM, the Lead Receptionist stated on resident #1 was coming to the	A 025		

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A 025	Continued From page 17 dining room from the hallway near the elevator. Adding, the resident had her walker when she . Further stating, she called the nurses to come, and they tried to get the resident up, but the resident stated her were weak. A facility note on at 9:00 AM read, at approx. 8:20 PM, Caregiver D notified the nurse to come to resident #1's apartment. The resident was observed sitting on her on the floor by the bed. Resident had proper footwear and staff last checked on resident 20 minutes prior and the resident was in bed resting. Resident did not press her call bell. On at 3:18 PM, Caregiver D stated resident #1 6 times in one day. She just kept falling. I told the prior Health and Wellness Director before she left, but the new staff were not aware. Resident #1 had a at the of her bed. Caregiver D stated when she walked in the resident was sitting on the floor next to the . She was not hurt and stated she slipped off the bed trying to get her M&M's. The that occurred on , the aid brought her down to the dining room and put her at the table and then resident #1 wanted to go outside. Adding, the resident first out of the wheelchair on the ground. A facility note on at 7:28 AM read, resident was heard calling for help at approximately 6 AM, upon entering room resident was found on the floor in the supine position. Her walker was next to her . The resident was barefoot and asked for help sitting up. Resident claimed she was getting ice cream from her freezer and slipped on some water. The floor was dry.	A 025		

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A 025	Continued From page 18 A facility note on at 7:09 AM read, resident occurred on at 6 AM, near the kitchenette area of resident's apartment. On at 3:08 PM, LPN E stated she worked the overnight shift when resident #1 slipped while getting ice cream. Adding, the resident stated she slipped because there was water on the floor but did not hit her . Further stating, as she was putting the resident to bed. She asked the resident again if she hit her and the resident replied yes. On at 4:40 PM, resident #1's POA stated the facility did everything within their means to keep resident #1 safe. She explained the resident had before moving into the facility and they were aware. The resident is moving to a long-term care due to the on . A facility note on at 7:28 PM read, s/p day #3, resident alert and verbally responsive with at times. A facility note on at 7:16 PM read, s/p day #2, resident is up and about. A facility note on at 7:24 PM read, post day #1, resident was seen ambulating with a walker throughout the facility today. A facility note on at 7:21 PM read, at approx. 3 AM, resident and was sent to Advent Health Apopka on night shift. Review of resident #1's personal service assessment dated stated assist x 1 pivot, requires assistance to and from the dining room and/or community activities, has in the past	A 025		

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A 025	Continued From page 19 12 months, and had memory loss of On at 10:31 AM, the Health and Wellness Coordinator (HWC) stated when resident #1 outside on she did not witness it but immediately went outside along with the Health and the Wellness Director. Adding, it was bad and she knew resident #1 was a risk. Furthermore, residents typically secure their wheelchairs. However, when staff members escort residents outside, they must always remain with them. Adding, she was not aware of a policy stating they were not allowed to lock the wheelchair. Further stating, when resident #1 twice on and then again on 8//27/25 she informed the prior HWD that the resident needed to go to the hospital and then requested from there rehabilitation center because she was weak and falling. The HWC stated the resident did not want staff to come into her room, but we reminded the resident that the staff needed to do more checks because she kept falling. On at 11:40 AM, the Administrator stated the policy states the facility is not allowed to lock the brakes on the wheelchair as it is a . After review of the Assistive Device Policy provided. The Administrator did not provide any additional documentation to support a policy which states the facility was not required to lock the wheelchairs for their residents. On at 11:45 AM, the Administrator, the HWD, and HWC confirmed the findings. (photographic evidence obtained) Class II	A 025		

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A 079	Continued From page 20	A 079		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels	A 079		

(3) STAFFING STANDARDS.
(a) Minimum staffing:
1. Facilities must maintain the following minimum staff hours per week:

Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week
0-5	168
	212
16-25	253
26-35	294
36-45	335
46-55	375
56-65	416
66-75	457
76-85	498
86-95	539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there

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A 079	Continued From page 21 must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in	A 079		

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A 079	Continued From page 22 meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the	A 079		

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A 079	Continued From page 23 minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Findings: Review of the and staff schedule and phone numbers did not reveal LPN E listed. On at 1:53 PM, the Health and Wellness	A 079		

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A 079	Continued From page 24 Director stated LPN E has not worked here for a while. Adding, she was a borrowed employee from another Brookdale. Review of resident #1's progress note revealed on at 7:09 AM, LPN E was first on the scene following the . On updated resident #1's medication observation record as 17 = hospitalization/leave of absence for , . Further reviewed revealed on updated 17=hospitalization/leave of absence for , . On at 2:06 PM, the Health and Wellness Director provided the , and schedules adding she does not have an , schedule that listed LPN E working at the facility. Further stating, she believes LPN E worked one weekend in , . On at 3:12 PM, LPN E stated she primarily works at Brookdale Lake Mary which is where she was hired. Further stated, she worked once a week or a couple of days during her training at Wekiwa Springs. Adding, on , she worked overnight when resident #1 . She stated sometimes she would be on the schedule for Brookdale Wekiwa Springs and other times the facility would call and ask Brookdale Lake Mary if she could come to help when they were short staff. (photographic evidence obtained) Class III	A 079		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service	A 081		

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A 081	Continued From page 25 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.	A 081		

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A 081	Continued From page 26 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents	A 081		

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A 081	Continued From page 27 must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an	A 081		

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	AL11965474	A. BUILDING: _____ B. WING _____	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEKIWA SPRINGS	203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703

(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 081	Continued From page 28 understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to obtain the staff in-service training for 2 of 6 sampled staff (C, E) within 30 days of employment as required. Findings: On at 1:53 PM, the Health and Wellness Director stated LPN E has not worked here for a while. She was a borrowed employee from another Brookdale. There was no documented evidence that a 2-hour pre-service orientation was completed prior to interacting with residents. No evidence of 1 hour resident rights and recognizing/reporting /neglect training and 1 hour reporting major incident, incident reporting. On at 9:28 AM, the Business Office Coordinator stated LPN E is no longer picking up shifts here and she did not obtain an employee file for here. Review of Caregiver C's record revealed a hire date on . The 2-hour pre-service orientation dated was not signed by Caregiver C and the Administrator for completion. There was no evidence of the 1-hour major incident, incident reporting was included.	A 081		

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A 081	Continued From page 29 On at 11:23 AM, the Business Office Coordinator confirmed the findings, adding Caregiver C does not have it. (photographic evidence obtained) Class III	A 081		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,	A 161		

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A 161	Continued From page 30 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity _____, to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure the record for 1 of 6 sampled staff contained a copy of the employment application, with references furnished (E). Findings: On at 1:53 PM, the Health and Wellness Director stated LPN E has not worked here for a while. She was a borrowed employee from another Brookdale.	A 161		

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A 161	Continued From page 31 On at 9:28 AM, the Business Office Coordinator stated LPN E is no longer picking up shifts here and she did not obtain an employee file for here. On at 3:08 PM, LPN E stated she primarily works at Brookdale Lake Mary which is where she was hired but completed her training at Brookdale Wekiwa Springs and that is where she completed her application. Class III	A 161		

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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ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ˬ , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on review of the facility's background screening clearinghouse and interviews, the facility failed to report the initial employment status within 5 business days for 1 of 6 sampled staff (E). Findings: On at 11:30 AM, review of the facility's background roster revealed Caregiver E, later identified as a licensed practical nurse (LPN) was not listed as an employee. On at 1:53 PM, the Health and Wellness Director stated LPN E has not worked here for a while. Adding, she was a borrowed employee from another Brookdale. On at 9:28 AM, the Business Office Coordinator stated LPN E is no longer picking up shifts here and was not added to the background	ZZ814		

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ZZ814	Continued From page 2 roster. On at 3:08 PM, LPN E stated she primarily works at Brookdale Lake Mary which is where she was hired but completed her training at Brookdale Wekiwa Springs. (photographic evidence obtained) Unclassified	ZZ814		
ZZ816 SS=D	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ␣ . to the Federal Bureau of Investigation for a national criminal history record check unless the person's ␣ , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ␣ , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ␣ , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ␣ . to the Federal Bureau of Investigation for a national criminal history record	ZZ816		

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ZZ816	Continued From page 3 check. The ␣ , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ␣ , . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying	ZZ816		

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ZZ816	Continued From page 4 offenses while employed by the employer. 59A-35.090 Background Screening. (d) Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the	ZZ816		

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ZZ816	Continued From page 5 Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to obtain a signed background screening compliance attestation for 2 of 6 sampled staff (E, F). Findings: On at 9:28 AM, the Business Office Coordinator was asked to provide the employee files for LPN E and Caregiver F. On at 10:00 AM, the Business Office Coordinator stated she was working with the HWD at Brookdale Lake Mary to fax LPN E's employee file for review. Adding, LPN E no longer is picking up shifts here and she did not obtain her file. Review of Caregiver staff F's record review revealed hire date on . There was no evidence documented of a signed background screening compliance attestation. On at 10:28 AM, the Business Office Coordinator confirmed she did not have the documents for LPN E and Caregiver F. Unclassified	ZZ816		
A 000	Initial Comments A complaint investigation #2025015864 and generator monitoring was conducted at Brookdale	A 000		

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A 000	Continued From page 6 Wekiwa Springs on /2025. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident	A 010		

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A 010	Continued From page 7 must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an	A 010		

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A 010	Continued From page 8 assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged	A 010		

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A 010	Continued From page 9 from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the	A 010		

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	AL11965474	A. BUILDING: _____ B. WING _____	12/02/2025

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A 010	Continued From page 10 facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency for 1 of 4 sampled residents (#1) as required in an assisted living facility (ALF). Findings: Review of resident #1's record revealed a facility's admission on . A 1823 health assessment did not identify the resident as a risk. A facility note on at 8:37 PM read, day #3 re admit, resident alert and oriented. A facility note on at 5:32 PM read, day #2 re admission, resident alert with . A facility note on at 8:20 PM read, day #1 return to facility, resident alert and oriented and able to make needs known, denies , or discomfort. A facility note on at 6:08 PM read, resident arrived at the facility at approximately 4:45 PM, noted to be ambulating with the use of her wheelchair. A facility note on at 1:05 PM read, power of attorney (POA) stated resident will be getting discharged to facility from Apopka Rehab. A facility note on at 1:11 PM read, resident near dining, stated, I hit my on the floor, sent to ER for evaluation. A facility note on at 11:20 PM read, resident occurred on 11:20am - dining room, was near no furniture.	A 010		

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A 010	Continued From page 11 On at 4:06 PM, the Health and Wellness Director stated she did the assessment on resident #1's return from rehabilitation center. Adding, she did not know why resident #1 was sent to rehabilitation center and did not know she was a resident at the facility. She explained upon the assessment she noticed her gait was unsteady, so she ordered , , and , . The Wellness Director stated she was unaware resident #1 was a risk and believed the current 1823 was valid. On at 11:45 AM, the Administrator, Health and Wellness Director, and Health and Wellness Coordinator confirmed the findings. (photographic evidence obtained) Class III	A 010		
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	A 025		

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A 025	Continued From page 12 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 13 This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 1 of 3 sampled residents (#1). Findings: Review of resident #1's record revealed a facility admission on . A 1823 health assessment indicated a medical history of , , no physical limitations and was not identified as a risk. Her activities of daily living (ADLs) indicated she needed supervision with ambulation, toileting, and transferring. An incident report dated stated the resident is an assist x 1 with transfers and cannot self-ambulate. The apparent cause was that the resident attempted to stand up unassisted and due to her unsteady gait, the resident when attempting to self-ambulate. The facility's Management Policy last revised stated, Residents who sustained a should have a post evaluation to consider-possible interventions reduce the potential for future and injury. The service plan is reviewed for potential interventions and updated as necessary. are tracked and trended as a clinical indicator for quality improvement opportunities. An Orlando Health report dated stated a female delivered to our facility as a alert after a out of her wheelchair	A 025		

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A 025	Continued From page 14 today after hitting a curb. Emergency Medical Services noted periorbital and to the forehead upon their arrival. Patient arrived with C-collar, on board, evaluated as a Glasgow Scale 12. She was hypertensive with Spontaneous in 200s. for post prophylaxis. A facility note on at 2:49 PM read, resident Power of Attorney advised that resident was out of , and the next step is rehab/skilled nursing. A facility note on at 7:00 PM read, at approx. 5:35 PM, resident was found outside on the sidewalk. It was noted that the resident was lying on the ground on her right-side wearing shoes, her wheelchair was off the sidewalk beside her. The resident was unable to speak and had a substance coming from her . The resident's right was and closed shut. Prior to the at approx. 5:26 PM, the resident was seen eating dinner in the main dining room. The resident left the dinner table and was trying to go outside but was redirected to her meal. At approx. 5:30 PM, the resident was seen going outside and at 5:32 PM a resident sitting in the dining room called out for help stating a resident had outside. A facility note on at 6:26 PM read, resident occurred on at 5:35 PM outside the front door witnessed by a non-Brookdale associate. On at 2:10 PM, resident #4, a non-Brookdale associate who resides in the independent living community stated she was	A 025		

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A 025	Continued From page 15 sitting in a chair facing the window looking outside of the dining room. She stated resident #1's wheelchair looked like it was on the street just suddenly tipped over on the ground. Adding, she did not see her hit the ground, but the resident did not move afterwards. Furthermore, she rose from her seat and began calling for assistance to go outside. On at 3:45 PM Caregiver C stated resident #1 can't really walk on her own. I knew she was a risk. I took her to the dining room that day and sat her at the table. I went to the kitchen to give them the menus for the residents upstairs. When I returned to the dining room, I saw resident #1 trying to go outside so I redirected her to the table. Resident #1 stated she didn't want to eat and wanted to go sit outside. Caregiver C stated, she pushed the resident in her wheelchair outside and left her near the front door. Adding, she did not lock the brakes on the wheelchair because it's a Brookdale policy that they're not allowed to. Further stated, it's a if the residents want to move and are unable to. A facility note on 8:37 PM read, day #3 re admit, resident alert and responsive A facility note on at 5:32 PM read, re admission; resident alert with , assisted with ADLs. On at 4:06 PM, the Health and Wellness Director stated she did an assessment on resident #1 to return to the facility. Adding, she did not know why resident #1 went out nor did she know she was a resident of the facility. Further stating, was the first resident #1 had since she started in her position at the	A 025		

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A 025	Continued From page 16 facility. The HWD stated she was unaware of the prior and that resident #1 was a risk. Adding the policy states the facility is not allowed to lock the wheelchair as it is considered a . Review of the facility's Mobility Assistive Device states communities are responsible for ensuring the safe usage of resident's mobility assistive devices. Mobility devices consist of wheelchairs for residents with mobility challenges, walkers to assist with balance, and canes that provide support and stability while walking. A facility note on at 8:20 PM read, day #1 return to facility: resident alert and oriented and able to make needs known. Resident ambulates using her wheelchair to main dining room. A facility note on at 6:18 PM read, resident arrived at the facility at approx. 4:45pm, noted to be ambulating with the use of her wheelchair. A facility note on at 1:05 PM read, POA stated resident will be getting discharged to facility from Apopka Rehab. A facility note on at 1:11 PM read, resident near dining, stated, she hit her on the floor, sent to ER for evaluation. A facility note on at 11:20 AM read, Resident occurred on 11:20 AM - dining room, was near no furniture. Resident stated she was trying to walk and she hit her . On at 2:00 PM, the Lead Receptionist stated on resident #1 was coming to the	A 025		

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A 025	Continued From page 17 dining room from the hallway near the elevator. Adding, the resident had her walker when she . Further stating, she called the nurses to come, and they tried to get the resident up, but the resident stated her were weak. A facility note on at 9:00 AM read, at approx. 8:20 PM, Caregiver D notified the nurse to come to resident #1's apartment. The resident was observed sitting on her on the floor by the bed. Resident had proper footwear and staff last checked on resident 20 minutes prior and the resident was in bed resting. Resident did not press her call bell. On at 3:18 PM, Caregiver D stated resident #1 6 times in one day. She just kept falling. I told the prior Health and Wellness Director before she left, but the new staff were not aware. Resident #1 had a at the of her bed. Caregiver D stated when she walked in the resident was sitting on the floor next to the . She was not hurt and stated she slipped off the bed trying to get her M&M's. The that occurred on , the aid brought her down to the dining room and put her at the table and then resident #1 wanted to go outside. Adding, the resident first out of the wheelchair on the ground. A facility note on at 7:28 AM read, resident was heard calling for help at approximately 6 AM, upon entering room resident was found on the floor in the supine position. Her walker was next to her . The resident was barefoot and asked for help sitting up. Resident claimed she was getting ice cream from her freezer and slipped on some water. The floor was dry.	A 025		

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A 025	Continued From page 18 A facility note on at 7:09 AM read, resident occurred on at 6 AM, near the kitchenette area of resident's apartment. On at 3:08 PM, LPN E stated she worked the overnight shift when resident #1 slipped while getting ice cream. Adding, the resident stated she slipped because there was water on the floor but did not hit her . Further stating, as she was putting the resident to bed. She asked the resident again if she hit her and the resident replied yes. On at 4:40 PM, resident #1's POA stated the facility did everything within their means to keep resident #1 safe. She explained the resident had before moving into the facility and they were aware. The resident is moving to a long-term care due to the on . A facility note on at 7:28 PM read, s/p day #3, resident alert and verbally responsive with at times. A facility note on at 7:16 PM read, s/p day #2, resident is up and about. A facility note on at 7:24 PM read, post day #1, resident was seen ambulating with a walker throughout the facility today. A facility note on at 7:21 PM read, at approx. 3 AM, resident and was sent to Advent Health Apopka on night shift. Review of resident #1's personal service assessment dated stated assist x 1 pivot, requires assistance to and from the dining room and/or community activities, has in the past	A 025		

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A 025	Continued From page 19 12 months, and had memory loss of On at 10:31 AM, the Health and Wellness Coordinator (HWC) stated when resident #1 outside on she did not witness it but immediately went outside along with the Health and the Wellness Director. Adding, it was bad and she knew resident #1 was a risk. Furthermore, residents typically secure their wheelchairs. However, when staff members escort residents outside, they must always remain with them. Adding, she was not aware of a policy stating they were not allowed to lock the wheelchair. Further stating, when resident #1 twice on and then again on 8//27/25 she informed the prior HWD that the resident needed to go to the hospital and then requested from there rehabilitation center because she was weak and falling. The HWC stated the resident did not want staff to come into her room, but we reminded the resident that the staff needed to do more checks because she kept falling. On at 11:40 AM, the Administrator stated the policy states the facility is not allowed to lock the brakes on the wheelchair as it is a . After review of the Assistive Device Policy provided. The Administrator did not provide any additional documentation to support a policy which states the facility was not required to lock the wheelchairs for their residents. On at 11:45 AM, the Administrator, the HWD, and HWC confirmed the findings. (photographic evidence obtained) Class II	A 025		

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A 079	Continued From page 20	A 079		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels	A 079		

(3) STAFFING STANDARDS.
(a) Minimum staffing:
1. Facilities must maintain the following minimum staff hours per week:

Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week
0-5	168
	212
16-25	253
26-35	294
36-45	335
46-55	375
56-65	416
66-75	457
76-85	498
86-95	539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there

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A 079	Continued From page 21 must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in	A 079		

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A 079	Continued From page 22 meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the	A 079		

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(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 079	Continued From page 23 minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Findings: Review of the and staff schedule and phone numbers did not reveal LPN E listed. On at 1:53 PM, the Health and Wellness	A 079		

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	AL11965474	A. BUILDING: _____ B. WING _____	12/02/2025

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A 079	Continued From page 24 Director stated LPN E has not worked here for a while. Adding, she was a borrowed employee from another Brookdale. Review of resident #1's progress note revealed on at 7:09 AM, LPN E was first on the scene following the . On updated resident #1's medication observation record as 17 = hospitalization/leave of absence for , . Further reviewed revealed on updated 17=hospitalization/leave of absence for , . On at 2:06 PM, the Health and Wellness Director provided the , and schedules adding she does not have an , schedule that listed LPN E working at the facility. Further stating, she believes LPN E worked one weekend in , . On at 3:12 PM, LPN E stated she primarily works at Brookdale Lake Mary which is where she was hired. Further stated, she worked once a week or a couple of days during her training at Wekiwa Springs. Adding, on , she worked overnight when resident #1 . She stated sometimes she would be on the schedule for Brookdale Wekiwa Springs and other times the facility would call and ask Brookdale Lake Mary if she could come to help when they were short staff. (photographic evidence obtained) Class III	A 079		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service	A 081		

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A 081	Continued From page 25 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.	A 081		

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A 081	Continued From page 26 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents	A 081		

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A 081	Continued From page 27 must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an	A 081		

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A 081	Continued From page 28 understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to obtain the staff in-service training for 2 of 6 sampled staff (C, E) within 30 days of employment as required. Findings: On at 1:53 PM, the Health and Wellness Director stated LPN E has not worked here for a while. She was a borrowed employee from another Brookdale. There was no documented evidence that a 2-hour pre-service orientation was completed prior to interacting with residents. No evidence of 1 hour resident rights and recognizing/reporting /neglect training and 1 hour reporting major incident, incident reporting. On at 9:28 AM, the Business Office Coordinator stated LPN E is no longer picking up shifts here and she did not obtain an employee file for here. Review of Caregiver C's record revealed a hire date on . The 2-hour pre-service orientation dated was not signed by Caregiver C and the Administrator for completion. There was no evidence of the 1-hour major incident, incident reporting was included.	A 081		

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A 081	Continued From page 29 On at 11:23 AM, the Business Office Coordinator confirmed the findings, adding Caregiver C does not have it. (photographic evidence obtained) Class III	A 081		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,	A 161		

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A 161	Continued From page 30 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity _____, to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interviews, the facility failed to ensure the record for 1 of 6 sampled staff contained a copy of the employment application, with references furnished (E). Findings: On at 1:53 PM, the Health and Wellness Director stated LPN E has not worked here for a while. She was a borrowed employee from another Brookdale.	A 161		

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A 161	Continued From page 31 On at 9:28 AM, the Business Office Coordinator stated LPN E is no longer picking up shifts here and she did not obtain an employee file for here. On at 3:08 PM, LPN E stated she primarily works at Brookdale Lake Mary which is where she was hired but completed her training at Brookdale Wekiwa Springs and that is where she completed her application. Class III	A 161		