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
	AL11965818	A. BUILDING: _____ B. WING _____	01/21/2026

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BROOKDALE LAKE MARY	150 MIDDLE STREET LAKE MARY, FL 32746

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ZZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	ZZ821		

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ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	ZZ821		

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ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Residential Mental Health Providers: Crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, and residential treatment centers for children and adolescents shall submit incidents as required by Section 394.907, F.S., and rules promulgated thereunder to the Agency within 1 business day of occurrence on Residential Mental Health Provider Incident Report, AHCA Form 3180-5008OL, , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-18470, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal 6. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 7. For the purposes of this rule, the following applies for submitting adverse incident reports:	ZZ821		

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ZZ821	Continued From page 3 a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days after a resident experienced an incident that resulted in a transfer to a hospital for 1 of 5 sampled residents (#1.)	ZZ821		

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ZZ821	Continued From page 4 Findings: Observations made on at 9:59 AM revealed resident #1 was sitting in a wheelchair near her room in the memory care common area. A purple and green , approximately 5 centimeters x 3 centimeters, was seen on her left forehead. The Program Coordinator of memory care was present and said that a caregiver was providing care to the resident when the resident's gave out and the resident hit her on the wall, causing the . A review of resident #1's record revealed a medical history of and . A health assessment form, dated , indicated the resident was a risk and needed assistance with ambulation. A review of a medication list, signed by a health care provider on , revealed the resident was prescribed the , , and . A review of a facility note, dated at 3:45 PM, revealed that two staff were assisting resident #1 in the bathroom. The note indicated the resident was holding on to the side bar and when she could not bear anymore, she tried to sit down and bumped her on the wall. The note indicated a hematoma was seen on her . The note indicated that the resident was transferred to a hospital. A review of a facility note, dated at 10 PM, revealed the resident returned from the hospital. A review of a hospital after visit summary, dated , revealed the resident was seen for a with injury.	ZZ821		

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ZZ821	Continued From page 5 During an interview on at 3 PM, the Wellness Director said she did not submit preliminary and full reports when the incident occurred, and the resident was sent to a hospital. Unclassified	ZZ821		
A 000	Initial Comments A complaint investigation (2025016326, 2025019227) and a generator monitoring were conducted at Brookdale Lake Mary on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.	A 025		

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A 025	Continued From page 6 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. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to provide adequate supervision for 1 of 5 sampled residents who ingested a laundry detergent pod. (#7)	A 025		

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A 025	Continued From page 7 Findings: A hospital record indicated resident #7 was admitted on and was discharged on . The record revealed that the resident swallowed a foreign substance, ingested a corrosive material, , had an , into the , , tract, elevated troponin and . The record indicated the resident's scan revealed a trace amount of fluid in the upper and mid , . Review of resident #7's Health Assessment Form dated revealed the resident had a medical history of 's . A facility note on at 3:58 PM, read the resident had consumed a small bit of powered laundry detergent at approximately 3AM. The resident was noted with slightly reduced appetite, a productive , and had a small amount of spit-up/ . The resident was sent out with emergency medical services at approximately 2:45PM. A facility note on at 7:49 PM, read the resident will be admitted to the hospital to perform overall monitoring. A facility note on at 4:28 PM, read resident was admitted to a hospital for acute . A facility note on at 3:03 PM, read resident returned from a hospital. During an interview on at 10:02 AM, caregiver A said she worked the 7 AM to 3 PM shift on . The caregiver said resident #7 did not eat his breakfast and when he opened his	A 025		

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A 025	Continued From page 8 she observed a blue substance. Caregiver A said she smelled resident #7's and it smelled of a soap-like substance. The caregiver said she gave the resident milk to drink and then informed Licensed Practical Nurse (LPN) E. During an interview on at 10:14 AM, caregiver B said on Nurse E sent resident #7 to hospital because the resident ate soap on the 11 PM to 7 AM shift. During an interview on at 12:01 PM, caregiver B said, the 11 PM to 7 AM shift told her on at approximately 7 AM, resident #7 ingested soap during the 11 PM to 7 AM shift. The caregiver said she observed resident #7 coughing persistently. Caregiver B said she went to call LPN E, and the resident was sent to the hospital. During an interview on at 12:30 PM, caregiver G said on at approximately 2 AM, she was in the memory care unit with caregivers F and H. Caregiver G said resident #7 was sleeping in the living room while she was doing the laundry. The caregiver said she was using white powder laundry soap pods for the laundry. Caregiver G said she placed the bag which contained the laundry pods on the railing against the wall near the laundry room door. The Caregiver said she then left the pods unsupervised on the railing and walked into the spa room. The Caregiver added when she came out of the spa room she got sidetracked and left the pods on the railing. Caregiver G said her was turned when resident #7 got up and left the living room. The caregiver said resident #7 was in the hallway, approximately four steps away from the laundry room door when he began to clear his . Caregiver G said the resident had	A 025		

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A 025	Continued From page 9 a white substance on his walker and the floor. The caregiver said she then placed gloves on and did a sweep of resident #7's . Caregiver G said the resident did not have a white substance inside nor on the outside of his . The caregiver said the only thing that came out of resident #7's was thick . The Caregiver said when she looked at the laundry pod, she could see bite marks on the pod. Caregiver G said the resident inhaled the laundry pod but did not ingest it because she did not see any white powder in the resident's . The caregiver said the laundry powder was spilling onto the floor and into her when she picked it up from the bag. Caregiver G said she sat down with resident #7 in the living room for two hours to monitor him and gave him milk to drink. The caregiver said after some time passed, the resident yellow . Caregiver G said she did not call a nurse after or during the incident because resident #7 did not seem like he was in distress and he stopped clearing his . The caregiver added she made a mistake when she left the laundry pod on the railing and should have locked it away. During an interview on at 1:23 PM, LPN E said on the morning of she walked into the memory care unit. She said resident #7 was watching TV in the living room. LPN E said caregivers F, G, and H came up to her to inform her of the laundry pod incident with resident #7. The LPN said she kept an on resident #7 and took his vitals, which were normal. LPN E said at approximately 8 AM she called a health care provider to inform them of the incident. The LPN said later in the day resident #7 was observed with a concerning closed . LPN E said she decided to send the resident to the hospital for evaluation because of the concerning	A 025		

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A 025	Continued From page 10 , LPN E said while she was waiting for emergency medical services to arrive; a memory care unit caregiver informed her that the resident twenty minutes prior. During an interview on at 2:13 PM, caregiver F said on at approximately 2 AM to 3 AM she was doing a walk-through of the memory care unit. The caregiver said resident #7 grabbed a bag with detergent powder in it and made it to the doorway of his room. The caregiver said caregiver G and H checked the resident's . Caregiver F said she did not see anything in the resident's , and she did not see anything on the floor. Caregiver F said she informed LPN E at approximately 7AM on . Caregiver F said she did not inform a nurse about the incident with resident #7 when it occurred because there was no nurse working at the time. Caregiver F added that she does not know why she did not call the wellness director to inform her. During an interview on at 3:08 PM, the Wellness director said she received a call on at approximately 2:45 PM from LPN E, informing her of the incident with resident #7. The Wellness Director said she did not receive a call from her staff prior to that time. The Wellness Director said she informed LPN E to send resident #7 to the hospital immediately to be evaluated. During an interview on at 3:22 PM, the Health and Wellness Coordinator said she was working in the morning on and she was not informed of the incident with resident #7 until approximately 2 PM. During an interview on at 4:09 PM,	A 025		

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A 025	Continued From page 11 caregiver H said on during the 11 PM to 7 AM shift, she was in the open television area in the memory care unit with resident #7, caregiver F, and caregiver G. Caregiver H said that caregiver G was doing laundry and left a bag with powder laundry substance next to the laundry room. Caregiver H said resident #7 got up and walked past her towards his room. The caregiver said resident #7 began to make a coughing sound. Caregiver H said there was a powder substance on the floor and on resident #7's walker. The caregiver said she does not know if resident #7 put the powder substance in his . Caregiver H said she did not notify a nurse of the incident because caregiver F was her supervisor and she was already present. A review of the facility's Resident Personal Care Items policy revised , indicated that if a medical emergency occurs with the consumption or ingestion of foreign substances into the body, the Health and Wellness Director/nurse/designee is responsible for calling 911 and the poison control center. (photographic evidence obtained) Class II	A 025		