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
	AL11965390	A. BUILDING: _____ B. WING _____	R 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST MELBOURNE	7199 GREENBORO DR WEST MELBOURNE, FL 32904

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(ZZ821) SS=D	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)		

AHCA Form 3020-0001

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

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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 record review and interview, the facility failed to electronically submit to the agency, a preliminary report within 1 business day of incident and a full report within 15 calendar days of the incident for 1 of 4 residents sampled. (#1) Deficiency Remained Uncorrected.	{ZZ821}		

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{ZZ821}	Continued From page 4 Findings: A review of resident #1's record revealed he sustained 4 unwitnessed . Three of the required transfer to the hospital. On resident #1 was transferred to the hospital with a injury requiring . On resident #1 was transferred to the hospital with a injury. A right parietal , soft tissue . On resident #1 was transferred to the hospital with a injury. He was diagnosed with a right parietal hematoma, subacute holohemispheric convexity collections 7mm left 5mm right. On at 6:15 PM, the Administrator confirmed he did not submit any Adverse Incident Reports to the agency for the incidents involving resident #1. Class III	{ZZ821}		
{A 000}	Initial Comments A revisit survey for complaint #2025019271 was conducted at Brookdale West Melbourne Assisted Living Facility on 3/192026. Two deficiencies remained uncorrected. A revisit survey to complaint investigation #2025019271 was conducted at Brookdale West Melbourne on . The facility had uncorrected deficiencies at the time of the visit.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision	{A 025}		

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{A 025}	Continued From page 5 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 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.	{A 025}		

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{A 025}	Continued From page 6 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to provide adequate supervision and care and services appropriate to meet the needs by failing to ensure safety through proactive measures to minimize the potential injuries resulting from resident-to-resident , involving resident #5 and #7. Findings: 1. On at 10:25 AM, resident #5 was observed sitting on the couch in the front lobby. He had purple discoloration around his right , . He was unable to recall how the injury occurred. On at 1:30 PM, an interview with a family member of resident #5 was conducted. She said someone called her from the facility on at about 7 AM. (no name, very heavy accent). The employee told her that resident #5 and his roommate resident #7 had an altercation. It was explained that resident #7 knocked resident #5	{A 025}		

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{A 025}	Continued From page 7 into the wall causing him to hit his . at 2 PM, Caregiver (A) confirmed in interview, resident #5 had a black , because sometime last night (-) resident #5 and his roommate #7 had some kind of altercation. On at 2:45 PM, an interview with resident #7 was conducted. He was observed standing in his room which he shared with resident #5. He recalled the incident between him and his roommate. He said he had to "drop" him because he was being . He could not recall what time the incident happened. He said that his roommate is very mean and tried to push him. On at 3 PM, an interview was conducted with caregiver (I). She stated on she was working with an agency aid. At around 6:30 PM, the agency aid alerted her that residents #5 and #7 were fighting. She said she went to their room and was able to separate them. She went on to say resident #5 had a scratch above and below his right , and resident #7 had a small on his . She said she was able to separate them and calm them down. She then put both to bed in the same room. Caregiver (I) confirmed they did not move either resident to ensure no further incidents. On at 4:10 PM an interview was conducted with resident #7's son and daughter via telephone. They confirmed the facility had notified them of the altercation between their dad and resident #5 but, not until at about 3:45 PM. They were made aware that resident #7 had a on his .	{A 025}		

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{A 025}	Continued From page 8 Review of resident #5's record revealed he was admitted on . His record contained a Resident Health Assessment form (1823) dated . His diagnoses included 's . The resident was independent with ambulation and transfer. Review of resident #7's record revealed he was admitted on . His record contained an 1823 dated . His diagnoses included , sundowning with , and . The resident ambulated with a walker. Further review of resident #7's record found no facility notes documenting the incident and no mitigating strategies to keep each resident safe. On at 4:40 PM, the Administrator confirmed there was a resident altercation incident on . He said he was not made aware of it until the morning of this survey . He was unable to provide a reason for notifying only resident #5's family in the morning, nor could he explain why neither family was informed immediately after the incident. He stated he called resident #7's family prior to this interview. He also said he was in the process of moving resident #5 to a different room. A review of the facility's policy on , neglect and , last updated revealed under 3a. Any associate who witnesses or becomes aware of alleged should report incident to the Executive Director (Administrator) or supervisor immediately. Under 4a Protection of resident. Upon learning of alleged , the Administrator or supervisor should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of .	{A 025}		

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{A 025}	Continued From page 9 Under 4c. Resident on resident contact. If an incident involves resident on resident contact, both residents should be separated and evaluated for change in condition. A review of the facility incident report completed by the 7 PM-7AM nurse (J) dated found the time of the incident was documented as 9:15 PM. The incident was witnessed by caregiver (I). The report contained documentation of resident #5's family being notified at 5:15 AM on and a voicemail left for resident #7's POA. On at 6:15 PM, the Administrator confirmed the findings. (Photo Evidence Obtained) Class II	{A 025}		