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
	AL11922279	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTBROOKE GARDENS	201 SUNSET DRIVE CASSELBERRY, FL 32707

(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 000	Initial Comments conducted Assisted Living Facility complaint inspection CCR#2013005711. There was a deficiency found at the time of the visit.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 1	A 025		

This Statute or Rule is not met as evidenced by:
Based on record review and interview the facility failed to provide adequate supervision and general awareness of whereabouts for 2 of 4 sampled residents (#3 & #4) to prevent elopement from the Memory Care Unit.

Findings:

1. Review of the adverse incident reports revealed #4 eloped from the secure Memory Care Unit (MCU) on at 11 AM. The resident took a lock off a window, opened window, climbed out of window and began walking away from facility. Staff came outside and attempted to redirect the resident back in to building. The resident resisted and continued to walk away. The staff member walked with the resident to a nearby gas station where the resident attempted to use the telephone. The nursing supervisor called 911 to assist with getting the resident back to the facility. According to police protocol, the resident was taken to the hospital for evaluation. There was no injury to the resident. Corrective action taken, resident given prescriptions for Risperidone Sertraine (antidepressant), replaced on window, more frequent checks on resident when not in sight of staff members.

Resident record review revealed an 1823 updated stated diagnoses of dementia, depression stated aggressive behavior. The resident was independent with ambulation, eating, toileting and transferring and needed assistance with bathing, dressing and grooming.

resident was known to the surveyor, as he

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	AL11922279	A. BUILDING: _____ B. WING _____	06/11/2013

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EASTBROOKE GARDENS	201 SUNSET DRIVE CASSELBERRY, FL 32707

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A 025	Continued From page 2 was relocated from a nearby ALF in 2013, where he had previously had multiple elopements. Review of facility notes revealed the resident was discharged from the facility due to aggressive behavior on . Interview with the RCD on at approximately 12:45 PM revealed the resident removed a safety device, that prevented the window from opening wide enough to exit through the window, off the front window in the activity , opened the window, took the screen off and exited the facility. Observation on at approximately 12:50 PM revealed the metal blocks with thumb screw safety devices were removed from the 4 front windows and a metal screw was screwed into the metal to prevent the windows from opening, in the activity . The windows could not be opened. Observation of the windows in the resident revealed their windows were secured with the same security devices and could not be opened. Interview with the administrator on at approximately 1:30 PM who stated the four front windows, in the activity , had the blocks with thumbs screws removed, had screws drilled into the window frames to prevent the windows from opening and the windows had alarms on them that would go off if the windows were opened. 2. Review of the adverse incident reports revealed #3 eloped from the secure Memory Care Unit (MCU) on at 17:43. The resident went to door that leads to lobby/outside, was able to open door and exited out to the lobby and then outdoors. Resident walked to nearby neighboring	A 025		

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A 025	Continued From page 3 home where the homeowner called the facility within 30 minutes. No injury to resident. Corrective action taken: new/different locking mechanism for door leading to lobby installed. The nursing staff was re-education on elopement procedures. Resident record review revealed an 1823 dated . . stated diagnoses of . . and . . The resident was agitated, exit seeking, asked repetitive questions and had poor judgment. The resident was independent with ambulation, dressing, eating, . . toileting and transferring and needed supervision with bathing. Observation on . . at approximately 11:15 AM revealed the door exiting the MCU to the entrance of the facility had a locking mechanism that required punching in a code. Interview with the RCD on . . at approximately 12:45 PM who stated the facility changed the lock on the front door, where the resident left the facility, and now it automatically locked, it is not manually locked with a key like the previous door. Class II	A 025		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Eastbrooke Gardens
201 Sunset Drive
Casselberry, FL 32707

Dear Administrator:

Re: CCR #2013005711

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **, 2013,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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