| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11922279 | 08/15/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**EASTBROOKE GARDENS** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**201 SUNSET DRIVE**<br>**CASSELBERRY, FL 32707** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 Initial Comments**

A complaint investigation was conducted (CCR#2016005775) on at Eastbrooke Gardens, License# 5355. A deficiencies were found at the time of the investigation.

**0025 Resident Care - Supervision**

Based on observation, interview and record review the facility failed to provide care and services (supervision) for 1 of 11 sampled resident (#1).

Findings:

1. In an interview on at 9:05 am with the Administrator, she confirmed Resident#1 was admitted to the facility on . She revealed he was placed at the secure facility due to be an elopement risk. She also stated Resident #1 did not receive 1:1 supervision. She stated Resident #1 eloped through a dining on . She also confirmed the staff may not have been aware Resident #1 was an elopement risk.

2. In an interview on at 9:45 am with the Director of Nursing, stated Resident #1 did not receive 1:1 supervision. She stated she and the staff were unaware Resident #1 was an elopement risk. She confirmed Resident #1 eloped on through a dining .

3. In a review of the 1823 on of Resident# 1, it revealed Resident #1 was an elopement risk.

4. In a review on of the facility's elopement policy it confirms the facility is responsible for informing all staff of the resident's history of elopement.

Class III

**0056 Medication - Labeling and Orders**

Based on observation, record review and interview the facility failed to provide Physician ordered medication for 1 of 11 sampled residents (#1).

Findings:

1. In an interview on at 9:05 am with the Administrator, she confirmed Resident #1's Physician

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11922279** | **08/15/2016** |
| NAME OF PROVIDER OR SUPPLIER **EASTBROOKE GARDENS** | STREET ADDRESS, CITY, STATE, ZIP CODE **201 SUNSET DRIVE CASSELBERRY, FL 32707** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

ordered medication for his escalating behaviors, dated / was never filled due to not having Resident #1's social security number. She stated he was discharged on .

2. In an interview on at 9:45 am with the Director of Nursing, she confirmed Resident #1's physician ordered medication dated / was never ordered due to not having a social security number and did not have the medication during his stay at the facility from to .

3. In a record review on of Resident #1's Physician ordered medication dated / , it revealed the medication was never filled during Resident#1's stay at the facility. It also revealed Resident #1 was not discharged until .

4. In a review on of the nursing notes on / / for Resident #1, it revealed Resident#1's behaviors escalated and was observed attempting to break a window in order to elope. It also confirmed on / , Resident #1 was prescribed a physician ordered medication for his escalating behaviors and the prescription was never filled.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Eastbrooke Gardens
201 Sunset Drive
Casselberry, FL 32707

**RE: CCR #2016005775**

Dear Administrator:

This letter reports the findings of a state licensure **complaint investigation** survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com