STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965424	04/11/2019
NAME OF PROVIDER OR SUPPLIER **BROOKDALE LAKE ORIENTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **217 BOSTON AVENUE** **ALTAMONTE SPRINGS, FL 32701**	

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

0000 - Initial Comments

Complaint Investigations #2019000813, #2019001107 and #2019001837 were conducted on and . Brookdale Lake Orienta had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observations, record reviews, and interviews, the facility retained 1 of 11 sampled residents (#4) who exceeded the continued residency criteria in an Assisted Living Facility (ALF), and failed to obtain a new 1823 health assessment form when 2 of 13 sampled residents (#3 & 4) experienced a significant change.

Findings:

1. On at 10:23 a.m., resident #4 said the facility staff had trouble getting him on and off the toilet as well as anytime he transferred. He said two people had to assist and the resident's would collapse. At 10:50 a.m., caregivers F and D entered his room, followed shortly thereafter by caregiver E. Caregivers F and D parked his wheelchair in front of his recliner, locked it, then transferred him by placing each of their arms under his then lifting him from the wheelchair and into the recliner. His body was rigid and he did not assist or pivot during the transfer. All three caregivers said he normally required total assistance with transferring and sometimes required the assistance of 3 caregivers.

The resident was admitted to the facility on . His current health assessment form (1823), dated , indicated that he required only assistance with transferring. His diagnoses included ,

A home health nursing start of care note, dated , indicated that he was unable to transfer and was unable to turn and position himself. A home health , evaluation, dated , indicated that he required with both bed mobility and transfers.

On at 11:20 a.m., observations made with the health and wellness director (HWD) revealed his private aide placed his wheelchair next to his recliner. She assisted him to lean forward, placed her arms under his, and lifted him from the wheelchair to his recliner. He did not assist or pivot during the transferring. The HWD confirmed he required total assistance to transfer.

A health care provider's note, dated , indicated the resident had a on his . His current 1823, dated , did not indicate that he had a , and his record

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did not contain documentation by the facility to indicate he developed the . A new 1823 was not completed when he developed the , which is a significant change.

2. Resident #3's record revealed a facility admission date of . His current 1823, dated , did not indicate that he had a . A home health start of care note, dated , indicated that he had a on his left heel. A facility skin observation form, dated , indicated that he had open areas/ and to see open area flowsheet. His record did not contain any additional facility documentation to indicate he developed the , and a new 1823 was not completed when he developed the , which is a significant change.

On at 12:45 p.m., the HWD confirmed the findings. An opportunity was provided for her to provide additional documentation, including the open area flowsheet referenced on resident #3's skin form. However, she was unable to provide anything else.

Photographic evidence obtained.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record reviews and interviews, the facility failed to provide care and services to meet the needs by failing to supervise 1 of 13 sampled residents (#7) who eloped from the facility from the secured memory care unit, failed to document in the record of 2 of 13 sampled residents (#3 & 4) who developed a , , and failed to document in the record of 1 of 13 sampled residents (#2) a hospital admission and that the family and health care provider were contacted.

Findings:

1. Resident #3's record revealed a facility admission date of . His current health assessment form (1823), dated , did not indicate that he had a . A home health start of care note, dated , indicated that he had a on his left heel. A facility skin observation form, dated , indicated that he had open areas/ and to see open area flowsheet, however, the record did not contain the flowsheet. His record did not contain any additional facility documentation to indicate he developed the .

2. Resident #4's record revealed a facility admission date of . A health care provider's note, dated , indicated that he had a on his . His current 1823, dated

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, did not indicate that he had a , and his record did not contain documentation by the facility to indicate he developed the .

On at 12:45 p.m., the health and wellness director (HWD) confirmed the findings. An opportunity was provided for her to provide additional documentation, including the open area flowsheet referenced on resident #3's skin form, however, she was unable to do so.

Photographic evidence obtained.

3. Record review for resident #7 revealed an 1823, dated , that noted a diagnosis of ; the health care provider noted he was an elopement risk, was a risk to ; the section that asked if the resident was a danger to self or others was noted as "Y", meaning yes, and that he was a risk.

Resident #7 resided in the facility's secured memory care unit.

Review of facility notes revealed on at 6:29 (AM or PM not noted) facility staff from front desk received a phone call from a woman who lived in the gated community next to the facility. The woman stated there was an elderly man in her backyard. The resident care coordinator for memory care unit responded to the call and went next door to see if he was one of their residents. He was and was escorted to the community while police followed.

On at 6:51 PM, the HWD called and stated "Visiting Angels" will be here between 8:30 PM and 9 PM for 24 hour service.

On , the resident tried to open a door that was lock, then he punch the door with his right . Staff wrote, "It appears that it hurt him because he kept on touching it and also there was a ."

, the resident alert and stable. He was discharged on .

On at 10:30 AM, the administrator was asked about the incident. The administrator said staff had to contact on the resident and knew where he was at all times. The administrator was shown the note that was written and he said he was provided incorrect information by staff.

The Resident Care Coordinator for the secured memory care unit said on at 12:30 PM that the facility received a call making them aware there was a gentleman found in the gated community behind the facility. She said she remembered the time being around the same time of the shift changing to the

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PM shift. She said she and another staff went to the community and found resident #7. She further stated the police arrived after she and the staff arrived and followed them to the facility. She said the facility staff was not aware of how long resident #7 had been missing. She said it was determined that the alarm on an egress gate that surrounded the outside courtyard of memory care was not working on the day resident #7 eloped. She said the resident was let out into the courtyard to walk around unsupervised and he was able to exit through the gate door. The maintenance director was present and confirmed the statement given by the memory care director.

Resident #7's record revealed a diagnosis of and that the resdient was an elopement risk. He was placed in the secured memory care unit for his safety. The facility did not provide the appropriate supervision to ensure that he remained safe at all times, and allowed him to leave the premises without staff knowledge.

4. Resident #2's record revealed a hospital discharge summary dated . A hospital history and physical from reflected that the resident had and increase . The resident did not improve and he was intubated.

The facility notes did not contain any documentation that noted the resident was transported to the hospital, the reason for the hospitalization, and if the health care provider anf family were aware of the hospital admission.

On at 2 PM, the HWD said she noted that the resident had labored breathing, and she had contacted the health care provider. She confirmed she did not document that the resident was transported to the hospital, and that the family and health care provider were aware of the transport to the hospital.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on record reviews and interviews, the facility failed to treat residents with consideration and respect when 1 of 13 sampled resident's (#4) call light was not answered in a timely manner.

Findings:

On at 10:23 a.m., resident #4 said he pushes his pendant (call for assistance) for help and sometimes waits hours for someone to respond.

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On at 11:27 a.m., his call response log was reviewed with the health and wellness director. On , his pendant rang at 11:21 a.m. and it was cleared at 12:44 p.m. This was a response time of 1.23 hours. On at 8:21 a.m., his pendant rang and was cleared at 9:25 a.m. This was a response time of 1.03 hours. On at 5:41 p.m., his pendant rang and was cleared at 7:14 p.m. This was a response time of 1.32 hours. On at 8:06 a.m., his pendant rang and was cleared at 9:32 a.m. This was a response time of 1.26 hours. The health and wellness director said she could not explain why the resident had the lengthy response times.

Photographic evidence obtained

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on medication pass observations and interview, the facility failed to ensure when unlicensed staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times.

Findings:

Observations on at 11 AM on the 3rd floor revealed staff A taking medications out of their packages, and placing them in a small cup but there were no residents present. Staff A was asked at the time if she was a nurse and she said that she was not. She said the resident #1 had to go the bathroom and she was preparing the medications for her when she returned. She continued to remove medications from their packages and placing the medications in a small cup. After she finished, she placed the medication package in the lock medication cart. There were 7 pills observed in the small cup.

Resident #13 walked off of the elevator at approximately 11-11:05 AM, and was about to enter his room that was next to the medication cart. Staff A told him to wait before he went in his room because she wanted to give him his medications. Staff A placed the other pills that were in the cup that belonged to resident #1 inside the cart. Resident #13 sat in a chair across from the medication cart that was outside of his room door. Staff A removed his medication packages and she read each label to the surveyor, and placed them in the small cup. After placing all of the medication in the cup, she took the medications cup with the pills to the resident. She began telling him the names of some of the medications. The resident kept saying "What did you say? Huh, huh?" when the caregiver spoke to

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him. The caregiver said the resident was hard of hearing, and could not understand what she was saying. The resident took the medications from staff A.

At approximately 11:10 AM on , resident #1 arrived at the medication cart. Staff A removed the small cup with her medication's from the cart and began telling her the names of some of the medications. In the presence of the resident, staff A did not read the label, open the container, remove the prescribed amount of medication from the container, and provide it to the resident as required.

At 11:20 AM on , staff A was informed of the findings. She said for resident #1 she began to give her the medications but she left to go to the bathroom and was just finishing them.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 3 sampled staff (B) received the required in-service training as described in 58A-5.0191( ) FAC.

Findings:

Caregiver B was hired on . Her personnel record did not contain a statement, signed by the administrator and employee, to indicate she received a preservice orientation of at least 2 hours. The record did not contain documentation to indicate she previously completed core training.

On at 1 p.m. the administrator confirmed the findings.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations and interviews, the facility failed to ensure that a resident's rooms were free from carpet stains and brown ceiling stains.

Findings:

1. Observation on at 9:40 AM revealed brown ceiling stains in the bathroom that was located on the left side of .

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2. Observation on at 10:30 AM revealed dark carpet stains in the living room of .

3. Observation on revealed carpet stains in the area outside of the dining room that was located next to the bathrooms.

4. On at 1 PM, the administrator confirmed the findings and said the carpets in were recently cleaned.

5. Observations made on at 9:55 a.m. revealed the bathroom ceiling in had a line of brown stain from the vent to where the ceiling and wall meet.

On at 1:25 p.m., the maintenance director confirmed the finding and said the stain was caused by a leak.

Class III

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on observations, record review and interview, the facility did not maintain a copy of a health care provider's order for the application and removal of a brace, and did not ensure that nursing services were conducted and supervised in accordance with Florida Statute Chapter 464, and the prevailing standard of practice in the nursing community for 1 of 4 sampled residents (#1) who received Limited Nursing Services (LNS) and allowed unlicensed staff to apply and remove a brace (a nursing service).

Findings:

On at 9:15 AM, the health and wellness director said there were no residents who received LNS.

Observations made on at 11:13 a.m. revealed resident #1 wore braces. She said the "aides" applied the braces every morning and removed them every evening.

At 11:17 a.m. on , both caregivers D and E (non-nurses) said they assist the resident by applying and removing her braces, which is an LNS task that unlicensed caregivers are not permitted to do.

On at 11 AM, resident #1 was observed with braces on both .

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On at 2:30 PM, the wellness director said she was not aware that resisdent #1 had braces and that the unlicensed staff were applying and removing the braces.

Class III

Z821 - Reporting Requirements; Electronic Submission - 59A-35.110 FAC

Based on record reviews and interviews, the facility failed to electronically submit to the agency, a preliminary report within 1 business day and a full report within 15 days of an elopement for 1 of 6 sampled residents (#7) who resided in the secured memory care unit.

Findings:

Resident #7's record revealed a resident heath assessment form 1823, dated , that noted a diagnosis of . The health care provider noted the resident was an elopement risk, and a risk to . The section that asked is the resident was a danger to self or others reflected "Y", meaning yes and that he was a risk.
Resident #7 resided in the facility's secured memory care unit.

Review of facility notes revealed on at 6:29 (AM or PM not noted) facility staff from the front desk received a phone call from a woman who lived in the gated community next to the facility. The woman stated there was an elderly man in her backyard. The resident care coordinator for memory care unit responded to the call and went next door to see if he was one of their residents. The resdient was escorted him to the community while police followed.

On at 10:30 AM, the administrator was asked about the adverse incident for the elopement. He provided another adverse incident for the resident that occurred on when the resident was found in a room in the ALF section. He said staff had to contact and knew where he was at all times during the event on . The administrator was shown the notes written regarding this elopement, said he was provided incorrect information by staff, and he had not completed an adverse incident report for the event.

Unclassified