| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11965370 | 05/02/2019 |
| NAME OF PROVIDER OR SUPPLIER<br>**BROOKDALE ALTAMONTE SPRINGS** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**360 MONTGOMERY ROAD**<br>**ALTAMONTE SPRINGS, FL 32714** | |

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

**0000 - Initial Comments**

Complaint Investigation #2019006611 was conducted on . , . . . Brookdale Altamonte Springs had a deficiency at the time of the visit.

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

Based on observations, record reviews and interviews, the facility failed to provide care and services appropriate to the needs of residents by failing to prevent a . . . . . outbreak, and failed to document in the record of 1 of 4 sampled residents was sent to the hospital and developed . . . . . symptoms (#1).

Findings:

Upon entering the facility on . . . . at 9 a.m., residents were eating breakfast in the dining room. At 9:30 a.m., the administrator said residents had been experiencing . and , and said the dining room and group activities were closed from . . . . until . . . . .

An email from the County Health Department to the facility, dated . . . . , recommended that the facility continue to restrict group activities and meals in the dining hall until 48 hours after the last case in the facility.

The facility's . . . . . case log revealed that between . . . . and . . . . , there were 58 residents with reported symptoms of . , or both, and since the dining room and group activities were reopened on . . . . , 7 new cases were reported.

At 10:57 a.m. on . . . . , residents were observed walking around the facility, eating meals in the dining room, and participating in group activities.

At 2:10 p.m. on , the administrator said the dining room and group activities were not closed again, as was previously recommended by the Health Department, when the first new case was reported on because "the people he reports to believed this did not have to happen until 10% of the resident population was affected" and although there were previous cases, the new case on . . . . was treated as "new" for the sake of counting the number of affected residents.

The facility's pandemic outbreak policy indicated that an outbreak is considered to be one case and the facility will follow recommendations from the local health department.

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

At 2:30 p.m. on , when asked what would constitute a pandemic outbreak based on the facility's policy, the health and wellness director said the current outbreak would.

The specimens, collected on , for residents #1, 7, and 8 all tested positive for Norovirus.

The facility's failure to follow its policy and follow the health department's recommendations to close the dining room services and group activities led to additional residents being afflicted with and .

On at 11:28 a.m. resident #1 said she had the and went to the hospital because of it and said she had for two days. A facility note, dated , indicated that she complained of post hospitalization. A facility note, dated , indicated that she had been weak and tired easily post hospitalization.

The facility's case log indicated that the onset of her was on .

Resident #1's record did not contain documentation to indicate she was sent to the hospital, and there was no documentation to indicate she had that was associated with the facility's surveillance of an outbreak.

At 2:45 p.m. on , the health and wellness director confirmed the findings and was unable to provide additional documentation.

Photographic evidence obtained.

Class II