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
	AL11965474	A. BUILDING: _____ B. WING _____	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEKIWA SPRINGS	203 S WEKIWA SPRINGS ROAD APOPKA, FL 32703

(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 A complaint investigation 2024008167, 2024007065 and generator monitoring was conducted at Brookdale Wekiwa Springs on [redacted]. The facility had a deficiency at the time of the survey.	A 000		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [redacted] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [redacted] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside	A 152		

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A 152	Continued From page 1 commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [redacted]. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interviews the facility failed to provide a safe living environment free of hazards and in good working order. Findings: On [redacted] observations revealed Resident #3 sitting in her room in a chair at the doorway entrance. Observations revealed [redacted]-like markings on both [redacted]. Resident #3 was asked about the incident that occurred on [redacted]. On [redacted] at 10:03am Resident #3 stated, "the [redacted]-like markings on my [redacted] and [redacted] are from the cabinet falling on me. I got up to use the bathroom in the middle of the night and the cabinet [redacted] on my [redacted], and I was pinned under the cabinet. I could not reach my pendant to call for help so I yelled out to my roommate. The paramedics came and helped me, but I didn't go to the hospital when it happened. Unlicensed care staff B came to help too. On [redacted] at 10:54am Resident #4 stated, "I was sleeping, heard a crash, and Resident #3 was yelling for me. I found Resident #3 on the toilet bent over with the cabinet on her [redacted], completely off the wall. We both pushed our call	A 152		

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A 152	Continued From page 2 buttons, and I came out of the room and pulled the red cord to notify the paramedics. The wood ., ... all over her. Once we got it apart, lifting partially off her she was able to get up. I recall yelling to the paramedics check her . . , check her . On observations revealed in . of Resident #2's bathroom a loose cabinet on the wall above the resident's toilet. It would appear the screws holding the cabinet were loose and not fully supporting the cabinet to the wall. Upon opening the two cabinet doors for an inside visual revealed the cabinet slightly leaning forward with a clear view of the . . . wall. On . . . . . at 11:05am Resident #2 entered the bathroom to observe the cabinet over the toilet, "stating oh my I hadn't notice. This would have on my if you didn't see it. Resident #2 began removing the contents from the cabinet. The Maintenance Manager was escorted to Resident #2's room to assess the cabinet located over the toilet in the bathroom. On at 11:15am after observation, the Maintenance Manager stated, "Resident #2 I will get this removed immediately." The Maintenance Manager was asked about the incident on . . . . . of the cabinet falling on Resident #3 and the repairs to the wall. On at 11:25am the Maintenance Manager stated, "I don't know any information about that referring to resident #3. I was just told about it. The incident that happened and a cabinet . . When I came into work, I removed	A 152		

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A 152	Continued From page 3 the cabinet from the hallway outside of the room and threw it away. It was broken into pieces I don't recall any repairs done to the wall. I have vendors who come in do painting of the rooms. Let me see if I can get a list of the vendors and the rooms painted." On at 12:45pm the Health and Wellness Coordinator stated, "here are the documents that was implemented after the cabinet on Resident #3. A review of the documents titled Wekiwa Springs Action Plan Audit Tool Weekly Room round. The documents listed each hall and the memory care unit. The dates were and of the rounds that were completed. Under date , indicated "N" under any issues noted including medications in room. On at 3:09pm Unlicensed care staff B was contacted via phone for an interview and no return call was received. On at 3:55pm the Administrator stated, "yes, we completed an incident report for Resident #3. The Health and Wellness Coordinator was asked about the documents provided which stated weekly room rounds but the dates indicate only revealed 2 days were completed. On at 4:16pm Clinical Service stated, "so from the last Agency for Health Care Administration (AHCA) survey we put this in place but we're not actually doing weekly. At the time we did this Resident #2's cabinet did not appear in need of repairs."	A 152		

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A 152	Continued From page 4 On . . . . . at 4:22pm the Administrator, Health and Wellness Coordinator, and Clinical Service . , ... confirmed the findings. (photographic evidence obtained) Class III	A 152		