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 _____	07/10/2025

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

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ZZ821 SS=D	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	ZZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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ZZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	ZZ821		

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ZZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	ZZ821		

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ZZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the agency a preliminary report within 1 business day of the incident and a full report within 15 calendar days of the incident for 2 of 11 residents sampled. (#11 and 2) Finding: On resident #1 walked up to resident #11 who was sitting on the sofa in memory care and slapped her across the . Caregiver (A) attempted to redirect resident #1 and he punched her in the abdomen. On at approximately 9:30pm, the caregiver heard a noise from resident #2 room. Upon entering the caregiver saw resident #1 and resident #2 physically fighting. The care giver stepped in between them resulting in resident #1 falling to the floor. Resident #2 sustained 2 small On at 10:30am the administrator confirmed she did not submit an Adverse Incident Reports to the agency for the 2 resident to resident incidents.	ZZ821		

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ZZ821	Continued From page 4 Class III	ZZ821		
A 000	Initial Comments A complaint #2025009804 investigation and generator monitoring were conducted on and at Brookdale Wekiwa Springs Assisted Living Facility Apopka. There were deficiencies identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and	A 025		

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A 025	Continued From page 5 services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, 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 resident. (c) Maintaining a 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. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to provide care and services, and supervision to meet the needs of residents. The facility failed to provide safety through proactive measures to prevent resident on resident for 3 of 11 sampled residents (#1,#11 and #2).	A 025		

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A 025	Continued From page 6 Findings: A review of two emails provided by the administrator to her from the Director of Nursing (DON) revealed on resident #1 walked up to resident #11 who was sitting on the sofa in memory care and slapped her across the . Caregiver (A) attempted to redirect resident #1 and he punched her in the abdomen. Review of the second email revealed on at approximately 9:30pm, caregiver heard a noise from resident #2 room. Upon entering the caregiver saw resident #1 and resident #2 physically fighting. The care giver stepped in between them resulting in resident #1 falling to the floor. Resident #2 sustained 2 small . On at 10:30am during a tour of the facility, resident #2 was observed in activities. The on his were resolved. He said he felt fine, and he was enjoying the class. Resident #1 was out of the facility during the survey. A review of resident #1 record revealed he was admitted on to the memory care Unit. His record contained a Resident Health Assessment form (1823) dated . His diagnoses included atrophy, , , , and agitation at night. The resident needs assistance with bathing. He was independent with other activities of daily living (ADL's). A review of the facility notes found the following: On nurse D was called to the memory care unit. Upon arriving at the memory care unit Nurse D heard the resident raising his voice	A 025		

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A 025	Continued From page 7	A 025		

loudly. The resident was redirected by Nurse D. An attempt was made to contact the Power of Attorney (POA). A voice mail message to return the telephone call.
On the resident got angry with another resident and was redirected.

Resident #11 was out of the facility at the time of the survey.
A review of resident #11 record revealed she was admitted on to memory care unit. Her record contained a Health assessment form 1823 dated . Her diagnoses included , and memory . The resident was independent with ambulation, eating, and transfer. She required supervision for toileting and assistance with bathing, , and grooming.

A review of the facility notes review did not find any documentation of the resident-to-resident incident which on at 11:30am.

3. A review of resident #2 record revealed he was admitted on to memory care unit. His record contained an 1823 dated . His diagnoses included the history of hematoma, , and unsteady gait. The resident was assessed as a risk and ambulated with a cane. He required supervision with all ADLs.

A review of the facility notes found no documentation of the resident-to-resident incident which occurred on .

On at 9:35am an interview with the Director of Nursing (DON) was conducted. A request was made to review the documentation

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A 025	Continued From page 8 or the notes for incidents of resident-to-resident involving resident #1 who had an incident with resident #11 and #2. The DON stated she reported both incidents to DCF. She attempted to look up the facility notes on her computer, but she was unable to provide any. The DON then provided the DCF reports submission on her computer. There was no documentation of the actual event. The information on the submission of the reports to DCF only showed the dates of submission. The DON said she notified resident #2 family. She was not sure who notified resident #11 family. The documentation of any proactive safety measures implemented after resident #1 slapped resident #11 to mitigate another resident-to-resident incident. On at 12:50pm The DON confirmed the facility did not implement and document interventions to mitigate resident to resident after resident #1 grabbed and slapped resident #11. 1 week after that event, resident #1 into resident #2's room and when asked to leave he and resident #2 had a physical altercation which caused to resident #2's right . A review of the facility policy dated last revised found under 4. c. Resident on Resident Contact. "If an incident involves resident on resident contact, both residents should be separated and evaluated for a change of condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address their behaviors." (Photo Evidence Obtained)	A 025		

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A 025	Continued From page 9 Class II	A 025		