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
	AL11965424	A. BUILDING: _____ B. WING _____	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LAKE ORIENTA	217 BOSTON AVENUE ALTAMONTE SPRINGS, FL 32701

(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 generator monitoring and a complaint survey (#2025012642) was conducted on at Brookdale Lake Orienta, Altamonte Springs. A deficiency was found at the time of the visit.	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 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	A 025		

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A 025	Continued From page 1 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 record reviews, interviews and observations, the facility failed to ensure daily observation of the activities of the resident while on the premises, and awareness of the general safety, and physical and emotional well-being of the resident, and to maintain a general awareness of the resident's whereabouts to prevent elopement for 1 out of 2 sampled residents (#1). Findings: A review of resident#1's admission record and health assessment dated confirmed an	A 025		

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A 025	Continued From page 2	A 025		

admission date . Medical history revealed , dependence with , cebral atrophy, high , and periods of . It also revealed the resident requires assistance with medications, ambulates with a rollator. Assistance with daily living included ambulation, bathing, , supervision with self-care, toileting and transferring. Resident was not an elopement risk, and residing in the assisted living unit at the time of the incident.

A review of the facility's observation notes confirmed the following:
On , Saturday evening the resident was propelling himself in and out of the front lobby area and he would sit out front and watch people. This evening he mentioned to receptionist he was being picked up by his sister. Receptionist kept an out for the resident. When he no longer in the front the receptionist reached out to the family to see if the family had him. She stated the family stated no. when the sister got to the mothers home she stated 2 men dropped him off and then the sister brought him to the facility. The resident was then placed in memory care.

In a review of the facility's elopement policy it states: elopement occurs when a resident who is at risk of harm due to their condition leaves the community unsupervised, or while in the community's care, leaves another safe location.

In an observation on at 12pm of resident#1, he was residing in the memory care unit, wearing an identification , stated he was on why he was at the facility and wanted to go home to his mother's home.

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A 025	Continued From page 3 In an interview on at 11:00am with resident#1's family member, stated the resident asked another resident's family to take him to his mom s home. She stated he thought his mother was coming to get him. She stated his mom , last . She stated he was not a or ever tried to leave the facility. She stated his abilities have declined and after the incident we decided to place him in memory care. She stated this was the first facility he had ever been in. He stated our mother used to take care of him. She stated they are very attentive to the resident. She stated her brother told the receptionist that his sister was coming to pick him up. She started that was not true. She stated the receptionist was just doing her job and the staff are not at fault with this. She started he is now in memory care. She stated that when he was first assessed the facility did not think he needed a memory care unit. She started that it is scary that he would ask a stranger for a ride home. He stated he was visiting a relative at the facility and her brother asked for a ride home. She stated she did not catch his name. In an interview at 11:50 am with staff B, she stated she works on the second shift and confirmed resident #1 is a and exit seeking. She stated the resident gets depressed a lot and wants to go home. She stated he was placed in memory care after the incident. She stated staff did not see him leave however the receptionist saw him outside and was informed his family was picking him up and he wanted to wait outside for them. She stated resident#1 should have been in the memory care unit from admission. In an interview at 12:30pm, staff D stated resident#1 has and exit seeking	A 025		

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behaviors when he was on the assisted living side. She stated now that he is in memory care he has not shown those tendencies. She stated he also had issues before he came to the memory care side. She stated he should never have been assessed for assisted living assistance as he should have come to memory care from admission. She stated this is based on his , and needs and his exit seeking behaviors.

In an interview at 12:45pm, staff E stated she was aware of resident#1's , and exit seeking behaviors when he was on the assisted living side. She stated he can be difficult at times but mainly will listen to staff. She stated the resident should have been placed in memory care from admission based on his exit seeking behaviors and safety issues.

In an interview on at 11am, staff A stated the resident never told her he was being picked up by family that day. She stated he was in the lobby, and she had asked him to go into the dining room and have dinner. She stated he then proceeded to go outside and sit by the end of the sidewalk. She stated she got busy at the reception desk. She stated she then received a call from resident#1's family member who informed her that she had the resident at her home and would bring him . She stated the family member stated two men from visiting the facility brought him from the facility to the family's home. She stated she did not know who the visitors were. She stated she did not know he was missing until the family member called her. She stated the resident would often get and ask where he was and why he was at the facility. She stated he would often say he wanted to go home. She stated she was not aware

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A 025	Continued From page 5 he was a exit seeker or . In an interview on at11:30am, staff C stated she would notice resident#1 would often ask why he was at the facility and ask if she could take him home. She stated there were days when he was and sure where he was. She stated he would often sit outside. She stated because he was on the assisted living side there was no need for additional supervision. In an interview at 1pm with the administrator, she confirmed the above statements and stated she does not know who the family members were that took the resident to the mother's home. She stated they checked the guest list but had been able to determine yet who it was. She stated the family wanted to put him the memory care at admission, but decided to try assisted living first. She stated after the incident he was placed in memory care unit. Photographic evidence was obtained Class II	A 025		