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
	AL11953460	A. BUILDING: _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DESTIN	2400 CRYSTAL COVE LANE SANDESTIN, FL 32550

(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 An unannounced complaint investigation for complaint numbers 2023003812 and 2023009095 was conducted in conjunction with a generator assessment at Brookdale Destin Assisted Living Facility on . Deficient practice was identified at the time of the survey.	A 000		
A 166 SS=D	429.23(5) FS; Risk Mgmt & QA; Reporting Reqs. 429.23, FS Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (5) Three business days before the deadline for the submission of the full report required under subsection (4), the agency shall send by electronic mail a reminder to the facility's administrator and other specified facility contacts. Within 3 business days after the agency sends the reminder, a facility is not subject to any administrative or other agency action for failing to withdraw the preliminary report if the facility determines the event was not an adverse incident or for failing to file a full report if the facility determines the event was an adverse incident. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit full adverse incident report (15-day report) for 1 of 5 sampled residents with a . (Resident #1) The findings include: A record review of adverse incident forms	A 166		

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
	AL11953460	A. BUILDING: _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DESTIN	2400 CRYSTAL COVE LANE SANDESTIN, FL 32550

(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 166	Continued From page 1 revealed an incident occurring on . . . for Resident #1 in their room. The report indicated that, during rounds, resident aides found Resident #1 on the floor after falling out of bed. Upon assessment, the resident was lying on her left side. The report stated that the upper left . . was noticeably larger than the right and the resident was experiencing a lot of , when the nurse touched the area. The nurse called hospice and was instructed to call the ambulance to have the resident sent to the emergency room for evaluation and . On at 7:15 pm, the adverse incident form was submitted to the agency. On at 3:46 pm, the Agency reviewed and accepted the preliminary report. On at 11:25 am, the Agency administratively closed the report because requested information for full report (15-day) was not received from the provider. On . . . . . at approximately 11:01 am, the Business Office Manager and an Administrator from another facility were interviewed. They reported that the previous health and wellness director oversaw the adverse incidents report and insured that the forms were submitted electronically to the agency. They acknowledged that staff did not submit the 15-day final report. Class III	A 166		

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
	AL11953460	A. BUILDING: _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DESTIN	2400 CRYSTAL COVE LANE SANDESTIN, FL 32550

(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 An unannounced complaint investigation for complaint numbers 2023003812 and 2023009095 was conducted in conjunction with a generator assessment at Brookdale Destin Assisted Living Facility on . Deficient practice was identified at the time of the survey.	A 000		
A 166 SS=D	429.23(5) FS; Risk Mgmt & QA; Reporting Reqs. 429.23, FS Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (5) Three business days before the deadline for the submission of the full report required under subsection (4), the agency shall send by electronic mail a reminder to the facility's administrator and other specified facility contacts. Within 3 business days after the agency sends the reminder, a facility is not subject to any administrative or other agency action for failing to withdraw the preliminary report if the facility determines the event was not an adverse incident or for failing to file a full report if the facility determines the event was an adverse incident. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit full adverse incident report (15-day report) for 1 of 5 sampled residents with a . (Resident #1) The findings include: A record review of adverse incident forms	A 166		

AHCA Form 3020-0001

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

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
	AL11953460	A. BUILDING: _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DESTIN	2400 CRYSTAL COVE LANE SANDESTIN, FL 32550

(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 166	Continued From page 1 revealed an incident occurring on . . . for Resident #1 in their room. The report indicated that, during rounds, resident aides found Resident #1 on the floor after falling out of bed. Upon assessment, the resident was lying on her left side. The report stated that the upper left . . was noticeably larger than the right and the resident was experiencing a lot of , when the nurse touched the area. The nurse called hospice and was instructed to call the ambulance to have the resident sent to the emergency room for evaluation and . On at 7:15 pm, the adverse incident form was submitted to the agency. On at 3:46 pm, the Agency reviewed and accepted the preliminary report. On at 11:25 am, the Agency administratively closed the report because requested information for full report (15-day) was not received from the provider. On . . . . . at approximately 11:01 am, the Business Office Manager and an Administrator from another facility were interviewed. They reported that the previous health and wellness director oversaw the adverse incidents report and insured that the forms were submitted electronically to the agency. They acknowledged that staff did not submit the 15-day final report. Class III	A 166		

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
	AL11953460	A. BUILDING: _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DESTIN	2400 CRYSTAL COVE LANE SANDESTIN, FL 32550

(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 An unannounced complaint investigation for complaint numbers 2023003812 and 2023009095 was conducted in conjunction with a generator assessment at Brookdale Destin Assisted Living Facility on . Deficient practice was identified at the time of the survey.	A 000		
A 166 SS=D	429.23(5) FS; Risk Mgmt & QA; Reporting Reqs. 429.23, FS Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (5) Three business days before the deadline for the submission of the full report required under subsection (4), the agency shall send by electronic mail a reminder to the facility's administrator and other specified facility contacts. Within 3 business days after the agency sends the reminder, a facility is not subject to any administrative or other agency action for failing to withdraw the preliminary report if the facility determines the event was not an adverse incident or for failing to file a full report if the facility determines the event was an adverse incident. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit full adverse incident report (15-day report) for 1 of 5 sampled residents with a . (Resident #1) The findings include: A record review of adverse incident forms	A 166		

AHCA Form 3020-0001

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

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
	AL11953460	A. BUILDING: _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DESTIN	2400 CRYSTAL COVE LANE SANDESTIN, FL 32550

(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 166	Continued From page 1 revealed an incident occurring on . . . for Resident #1 in their room. The report indicated that, during rounds, resident aides found Resident #1 on the floor after falling out of bed. Upon assessment, the resident was lying on her left side. The report stated that the upper left . . was noticeably larger than the right and the resident was experiencing a lot of , when the nurse touched the area. The nurse called hospice and was instructed to call the ambulance to have the resident sent to the emergency room for evaluation and . On at 7:15 pm, the adverse incident form was submitted to the agency. On at 3:46 pm, the Agency reviewed and accepted the preliminary report. On at 11:25 am, the Agency administratively closed the report because requested information for full report (15-day) was not received from the provider. On . . . . . at approximately 11:01 am, the Business Office Manager and an Administrator from another facility were interviewed. They reported that the previous health and wellness director oversaw the adverse incidents report and insured that the forms were submitted electronically to the agency. They acknowledged that staff did not submit the 15-day final report. Class III	A 166		