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
	AL11965335	A. BUILDING: _____ B. WING _____	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH	5111 PALMER RANCH PARKWAY SARASOTA, FL 34238

(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 relicensure, emergency power plan, health facility reporting system, generator, visitation form, and complaint survey for #2022015350, #2023008172, #2023008370, and #2023009270 was conducted on through at Brookdale Palmer Ranch, an assisted living facility in Sarasota, Florida. Complaint #2022015350 was unsubstantiated. Complaint #2023008172 was unsubstantiated. Complaint #2023008370 was substantiated at A165 and Z814 Complaint #2023009270 was unsubstantiated. The following is a description of the deficiencies.	A 000		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage;	A 165		

AHCA Form 3020-0001

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

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A 165	Continued From page 1 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall	A 165		

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A 165	Continued From page 2 determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to thoroughly investigate and report an adverse incident for one (Resident #17) of one resident surveyed for adverse incidents related to . Findings Included: Review of Resident #17's Health Assessment -	A 165		

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A 165	Continued From page 3 Form 1823 dated . . . . . shows the resident had a history of , , , loss, abnormalities of gait and mobility, and . . . of the . The 1823 shows Resident #17 is a Hospice resident. A . risk evaluation dated 11/30/23 shows Resident #17 was assessed as being a level 2 risk. On . . . at approximately 1:30 p.m. the Administrator stated level 2 risk was considered a moderate . risk and would be considered for should include interventions for preventing . . . Review of Resident #17's "Care Profile" showed no interventions to prevent . A "Post Evaluation" dated shows Resident #17 . at 5:00 p.m. in the memory care living room. The form shows the was witnessed by one staff member. The form shows Resident #17 attempting to get out of a chair. The form shows the resident's service plan included the use of a wheelchair instead of ambulation. On . . . . at 1:44 p.m. Registered Nurse, Staff N verified she had completed the post evaluation on . . . . She stated Resident #17 was attempting to get out of the chair in the living room area of the memory care when she . . She stated two staff members had witnessed the . . Staff N said Resident #17 did not usually attempt to stand on her own. She stated the resident could not move herself from her wheelchair to the chair without staff assistance. Staff N stated staff had to push Resident #17's wheelchair for her mobility she could not move	A 165		

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A 165	Continued From page 4 the chair on her own. Staff N said she did not know why staff had transferred the resident from her wheelchair to a chair in the memory care living room. Staff N verified there had not been any witness statements documented of Resident #17's . Staff N said Resident #17 remained in the skilled nursing rehabilitation facility due to a , . Staff N said she was not aware of what Level 2 risk was. On at 1:50 p.m. the Wellness Director said she was not aware of what level II risk assessment was. On at 1:52 p.m. the Administrator verified Resident #17's , had not been reported as an adverse incident. The administrator verified he could not provide documentation of witness statements of the resident falling, he could not provide documentation of interventions in place at the time of Resident #17's .	A 165		