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
	AL11911906	A. BUILDING: _____ B. WING _____	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DEER CREEK SARASOTA	8450 MCINTOSH ROAD 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 complaint survey for #2024004060 was conducted on [redacted] through [redacted] at Brookdale Deer Creek, an assisted living facility in Sarasota, Florida. Complaint #2024004060 was substantiated with citation. Deficiencies at A0030 and A0083 at a Class II Level The following is a description of the deficiencies.	A 000		
A 025 SS=D	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 [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 [redacted] 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	A 025		

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A 025	Continued From page 1 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 record review, family and staff interview, the facility failed to notify a resident's heath care provider, family/power of attorney, or call Emergency Medical Services when a change in condition occurred for 1 (Resident #1) of 3 resident records reviewed. Findings included:	A 025		

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A 025	Continued From page 2 Facility Policy "PL.6-017), Change of Condition last revised revealed: "The supervisor or designee should follow up with the client and/or responsible party regarding the change of condition." Clinical Record review for Resident #1 noted the resident was admitted to the facility on after a rehabilitation stay for a with a . Resident #1's Risk Evaluation form completed on noted Resident #1's risk score was level 3, the highest score for risk at the facility. The facility Incident log noted Resident #1 had 2 , a on and again on . The facility incident investigation revealed Resident #1 on and was found: "lying in bed at 4:22 a.m. during rounds with noted on the floor of her apartment near the bathroom. The trail led to Resident #1's bed. was documented to be coming from the of Resident #1's . The event was reported to Supervisor Staff C who instructed the care staff to send Resident #1 to the hospital due to a injury. Resident #1 was admitted to the hospital with hematoma ( ) and was later referred to hospice." On at 10:30 a.m., Supervisor Staff C said she received a call from the facility at 4:30 a.m. She said Caregiver Staff B told her Resident #1's was , there was on the pillow, and a trail leading to the bed from the bathroom. Staff C said she instructed the caregiver to "call 911 and send her out." Staff C said she told Staff B, "day shift would call the family." Staff C said: "When Caregiver Staff E	A 025		

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A 025	Continued From page 3 arrived for day shift at 6:09 a.m., she reported to me (Staff C), he (Staff B) didn't send her out, he didn't do anything." Staff C said staff are expected to complete an incident report but he did not. On . . . . . at 11:00 a.m., during a telephone interview, Staff B said: "I saw Resident #1 in bed at 4:00 a.m., with . . . . on her pillow, and on the floor." Staff B said, "I called Staff C and was told to give her the option to call 911 or leave her for the morning nurse to assess her. So, in the morning I let them know when they came in." Staff B did not notify the health care provider or the family of the injury. On . . . . . at 11:30 a.m. in an interview, the daughter/POA said they didn't tell me anything to begin with. She said, "finally at 9:30 a.m. I got a call from Brookdale, so I don't know where the breakdown was, but I was very upset." On . . . . . at 1:00 p.m., the Health and Wellness Director (HWD) verified there was no documentation of any communication with the family. The HWD said, " I know if it is not documented it did not happen. I understand there is an issue here. We did not document as we should." On . . . . . at 9:35 a.m., the Administrator said, "facility protocol is to call the family at the time the resident is sent to the hospital. The HWD and I called a couple of hours later." Class II	A 025		

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A 030	Continued From page 4	A 030		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the	A 030		

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A 030	Continued From page 5 facility's policies regarding: 1. Resident responsibilities; 2. [redacted] and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident [redacted], neglect, and [redacted]; 6. Administrative and housekeeping schedules and requirements; 7. [redacted] control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical [redacted]. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State	A 030		

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A 030	Continued From page 6 of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when	A 030		

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A 030	Continued From page 7 prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.	A 030		

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A 030	Continued From page 8 (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.	A 030		

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A 030	Continued From page 9 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, staff interview, the facility failed to provide an environment free from neglect for 1 (Resident #1) of 3 resident records reviewed. The facility staff failed to provide appropriate care to a resident with a requiring transfer to the hospital in a timely manner. The delay of care contributed to the deterioration of the health of the resident. Findings included: Facility Policy "PL.6-017), Change of Condition last revised revealed: "The supervisor or designee should follow up with the client and/or responsible party regarding the change of condition."	A 030		

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A 030	Continued From page 10 Clinical Record review for Resident #1 noted the resident was admitted to the facility on ... after a rehabilitation stay for a with a , ... Resident #1's . Risk Evaluation form completed on noted Resident #1's risk score was level 3, the highest score for risk at the facility. The facility Incident log noted Resident #1 had 2 . ., a . on ... and again on .. ... . The facility incident investigation revealed Resident #1 on and was found: "lying in bed at 4:22 a.m. during rounds with noted on the floor of her apartment near the bathroom. The . . . trail led . . . to Resident #1's bed. was documented to be coming from the . . . of Resident #1's . . . . The event was reported to Supervisor Staff C who instructed the care staff to send Resident #1 to the hospital due to a injury. Resident #1 was admitted to the hospital with . . . . . hematoma ( ) and was later referred to hospice." On . . . . . at 9:54 a.m. in an interview, Caregiver Staff D said when she arrived to work for the day shift, She was told by Caregiver Staff B, as he was leaving, that Resident #1 had , and he was told by Supervisor Staff C not to call 911. "He made it sound like she was not hurt, so I didn't panic. Then Caregiver Staff F and I went to check on her and we saw . . on the pillow, on the . . . of her . . . and down the front of her clothes. We told the Med Tech Staff E and started cleaning her up." Staff E called 911. Staff D said the caregivers are expected to check on	A 030		

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A 030	Continued From page 11 the residents at least every 2 hours. She said in and Neglect training, and training they are told to check everyone, - call 911, call family, anything broken - call 911. She said the process: evaluate for safety, check for radio for nurse and take further direction from the nurse. On at 10:30 a.m., Staff C said she received a call from the facility at 4:30 a.m. She said Caregiver Staff B told her Resident #1's was , there was on the pillow, and a trail leading to the bed from the bathroom. Staff C said she instructed the caregiver to "call 911 and send her out." Staff C said she told Staff B, "day shift would call the family." Staff C said: "When Caregiver Staff E arrived for day shift at 6:09 a.m., she reported to me (Staff C), he didn't send her out, he didn't do anything." On at 10:43 a.m., Caregiver Staff E said when she was arriving for work on , "As I was passing Staff B at the door, he stated, 'she needs hospital' with no other direction". Staff E said she called 911 at 6:15 a.m. and reported to that Resident #1 had an unwitnessed and had a injury. Staff E said if someone , check them out; if they are or not, or not safe call 911. Tend to the person, provide first aid. Check their vitals until comes. Complete an incident report by the end of shift prior to leaving." On at 11:00 a.m., in a telephone interview, Staff B said he saw Resident #1 in bed at 4 something with on her pillow, and on the floor. Staff B said, "I called Supervisor Staff C and was told to give her the option to call 911 or leave her for the morning nurse to assess her	A 030		

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A 030	Continued From page 12 and let them know what was going on. So, in the morning I let them know when they came in. I don't find any paper to send with her, or to do an incident report." Staff B did not notify the health care provider or the family of the injury. On . . . at 12:00 p.m., Staff A said they should have called 911, she said she asked Staff B a couple of times, and he said no about calling 911. She said she was just filling in and taking his lead. On at 1:00 p.m., the Health and Wellness Director (HWD) said the caregiver staff should have received training on with injuries and calling 911 as part of the initial orientation. Class II	A 030		
A 083 SS=G	59A-36.011(5) FAC Training - First Aid and . (5) FIRST AID AND . . . . . ( ). A staff member who has completed courses in First Aid and . and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American . . . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency	A 083		

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(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 083	Continued From page 13 medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the community had at least one staff member trained in [illegible] ( ) and First Aide (FA) on the premises at all times. Failure to ensure a /FA trained staff member was on the premises, identified to other staff members, and having the expectation of service in an emergency, led to Resident #1's delay in care being provided to a . This lack of care care contributed to the deterioration of the health of the resident. The findings included: Facility Policy, clinical services: , revised [illegible] said, "States Requiring a Certified Associate on Staff at all Times." A review of the facility records showed the facility had a census of 20 residents who had the potential need for interventions by /FA trained staff. Three of residents were 'Full Code'; that is, to receive in the event of a life-threatening [illegible] Employee list provided by the Business Office Coordinator revealed only 2 full-time employees are certified and no staff members had First Aid Certification. Record review revealed Resident #1 was admitted to the facility on [illegible] and discharged to the hospital on . Resident #1 and	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911906	A. BUILDING: _____ B. WING _____	03/26/2024

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BROOKDALE DEER CREEK SARASOTA	8450 MCINTOSH ROAD 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 083	Continued From page 14 sustained a large . . . . . First aid to control was not provided until Emergency Medical Services arrived nearly 2 hours later. On at 9:54 a.m., Caregiver Staff D said, "I saw . . . on the pillow, on the . . . of her and down the front of her clothes. There was a gash on the . . . of her . . . , I didn't want to touch it." On at 10:30 a.m., the Business Office Coordinator said Caregiver Staff B called me at 4:30 a.m. He said he saw a lot of on Resident #1's . . . , on the pillow and a . . . . trail on the floor. I said call 911. Staff E told me at 6:09 a.m., Staff B "didn't send her out, he didn't do anything." Staff are expected to complete an incident report, but Staff B did not. On . . . . . at 10:43 a.m., Staff E said Staff B was supposed to send the resident to the hospital. On at 11:00 a.m., Staff B said "I saw her in bed. I called Staff C and was told to give her the option to call 911 or leave for the morning nurse to assess her. So, in the morning I let them know when they came in. I don't find any paper to find an incident report and I didn't see anything to do that first aid." On at 1:00 p.m., the Corporate Health and Wellness travel nurse said, "No one did first aid, there is a bucket they could have brought to her room, it has gauze . . . cleanser, basic first aid supplies, she had from 4:00 a.m., until she was sent out by . . . . at 6:40 a.m." On at 8:30 a.m., Facility caregiver Staff A said Staff B called her to the room at 4:00 a.m.,	A 083		

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
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A 083	Continued From page 15 and I saw the . . . . . Staff B said not to call 911, he said wait for the nurse. Staff A said, Resident #1's " . . . . was still . . . . . . I didn't apply anything because I'm not a nurse and I was new. I asked again about calling 911 but he was very serious about no need to call 911." On at 12:00 p.m., Staff C and the Executive Director both verified an employee is required to have /FA in the building at all times. Staff C confirmed there was not a /FA trained staff member working when Resident #1 . . Class II	A 083		