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
	AL11964437	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PUNTA GORDA ISLES	250 BAL HARBOR BLVD PUNTA GORDA, FL 33950

(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 relicensure, limited nursing services, emergency power plan monitoring, and complaint investigation #2025013481 was conducted at Brookdale Punta Gorda Isles on thorough . The facility had no deficiencies at the time of the survey.	A 000		
A 165 SS=D	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; 3. Permanent ; 4. or 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	A 165		

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A 165	Continued From page 1	A 165		

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) , neglect, or . 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 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.

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A 165	Continued From page 2 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 record review, and interview, the facility failed to complete a 15-day adverse incident report for a resident who required a higher level of care for 1 (Resident #11) of 1 resident reviewed for adverse incident reporting. The findings included: Brookdale Senior Living Reportable Events Grid last Revision . . . Resident Care: . . . 3. Attempted or : Incident Investigation Form AL (assisted living) or SNF (skilled nursing facility). Time Frame to Notify: ASAP [as soon as possible] no later than 24 hours.	A 165		

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A 165	Continued From page 3 Brookdale Senior Living Solutions AHCA Adverse Incident Reporting, Effective , Last Revised: , "Policy Overview: The purpose of this guideline is to outline the procedures for reporting adverse events to AHCA consistent with the requirements of Florida Law. . . Policy Detail: . . . 4. The Executive Director, Health and Wellness Director and or designee will complete the "Assisted Living Facility Complete Adverse Incident Report - 15 day" form and submit it to ACHA [sic] within fifteen calendar days after the occurrence of the adverse incident by electronic submission in the ACHA [sic] website." Review of Resident #11's record revealed Resident #11 was admitted to the facility on . Review of the Health Assessment Form 1823 dated , revealed the resident was diagnosed with Generalized , , , , , Major , , and Positioning . Section 2. Self-Care and General Oversight Assessment - Medications: B. Does the individual need help with taking his or her medications (Meds) - No is checked. Also the box beside Able to Self-Administer Medications, Resident does not need staff assistance was checked. Review of the progress notes found on at 8:04 p.m., documented Resident #11's family member called the facility to let the nurse on duty know Resident #11 had taken 50 pills from 2 bottles of his medications. The nurse upon arriving at Resident #11's room asked what was taken and why. Resident #11 verified he had taken all of the and a handful of	A 165		

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A 165	Continued From page 4 , because "I am depressed and I don't want to be here." Resident #11 was sent out to the Hospital with . The nurse further documented that the medications the resident was self-administering were removed from his room and secured. During an interview on at 8:45 a.m., Resident #11 verified the incident of . Resident #11 stated, "I was feeling really depressed before I took those medications. I lost my [spouse] and was feeling lonely. I was doing my own medications when I moved in. Now they do it for me. I don't have an issue with that - it is one less thing to worry about. I had never felt like that before. I never talked to anyone about it before the incident. I was seeing a psychiatrist but never had a plan before. I called my [family member] when I took the pills, and [family member] called the facility to inform them. I now see another , and just finished a program on Friday. I am feeling better now. I think my issue was with not sleeping and I was taking medications for that, but now I have discontinued them and am sleeping better. My [spouse] was diagnosed with and for the last year of life, I stayed awake at night because [the spouse] would be up at night and would , so I would stay awake to take care of my [spouse]. I was so used to not sleeping, but now I am sleeping through the night." Record review of Reportable Events found 2 had been filed. One report was filed in both 1-day and 15-day. A second report was filed in both 1-day nd 15-day. During an interview on at 1:58 p.m., the Administrator said he had contacted Corporate about the incident report and he was told to file	A 165		

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A 165	Continued From page 5 the 1-day report. The 15-day report should have been filed by . Instead of filing the 15-day report the Administrator was directed by Corporate to close with no 15-day report as the "Situation with [Resident #11] had resolved." He said they had a reportable events grid which they were to follow. Class III .	A 165		