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 _____	R 12/30/2025

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 revisit by desk review to the relicensure, limited nursing services, emergency power plan monitoring, and complaint investigation was conducted for Brookdale Punta Gorda Isles on through . Deficiencies were identified 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 staff interview, the facility failed to complete a 1-day preliminary adverse incident report and/or complete the report within 15 days for a resident who required transfer to a higher level of care for 2 (Resident #11 and #100) of 2 residents reviewed for adverse incident reporting. This is a repeat deficiency. The findings included: 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	{A 165}		

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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."

1. Review of the progress notes for Res #11 revealed on at 8:04 p.m., 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 , because "I am depressed and I don't want to be here." Resident #11 was sent out to the Hospital via . The nurse further documented that the medications the resident was self-administering were removed from his room and secured.

On , at 2:17 p.m., in a phone interview, the Director of Health and Wellness (DHW) confirmed the original 1-day adverse incident report had been submitted but the Adverse report had not been fully completed within 15 days for Res #11. She said the 1-day report had been withdrawn under the direction of corporate because Res #11 was in the hospital and it was no longer needed.

2. Further record review revealed on , Res #100 was found sitting in the dining room for breakfast. She then was seen lying on the floor between two tables up against the wall. She did not have her walker. She sustained a bump to her

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{A 165}	Continued From page 4 and 2 skin rears to her left . The facility Nurse Practitioner was made aware and the resident was sent 911 to the local Emergency Room for evaluation and treatment, (which is a higher level of care). On at 10:30 a.m. in a phone interview, the DHW said the facility did not complete a 1 day preliminary incident report because it did not meet the criteria for reporting. Class III	{A 165}		