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 _____	01/26/2026

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 A complaint investigation for #2026000701 was conducted at Brookdale Deer Creek Sarasota on . Deficiencies were identified at the time of the survey.	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 or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . 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 , , 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 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 (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, and staff interview, the facility failed to provide proper supervision to 1 (Resident #1) out of 3 residents reviewed. The findings included: Requested and obtained policy titled: Night Checks Policy CS-100-16. Effective date: . Last revised: . Policy Overview: Resident care associated should conduct night checks of the residents. . . Policy Detail: 1. Associates should perform night checks	A 025		

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A 025	Continued From page 2 approximately every four (4) to six (6) hours, unless refused by the resident or as determined by the residents' need. 2. When performing a night check, associates should open the door to the resident's apartment quietly and observe the resident from a reasonable distance. . . 3.b. Associates should document in the Resident Log or Point and Click Care (PCC) Progress Notes the reason the room was entered and the outcome. Handwritten Verbiage: "Every 2 hours," then the name of the facility. Record review showed that Resident #1 was admitted to the Facility on . There was a on record dated . Health assessment review indicated a diagnosis of , , , , , and . Resident #1 was under Hospice care as on with diagnosis: Unspecified protein calorie . Other diagnoses included: , , Bradacardia, , Psych behavioral factors associated with the , , , type 2 non dependent, and , . Service plan for Resident #1 that was developed on did not have specific language for monitoring overnight or assisting to get undressed and assisted in to bed. Progress note review for Resident #1 indicated the resident expired on with time of documented as 7:38 a.m. per hospice representative in the building.	A 025		

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A 025	Continued From page 3 During an interview on at 10:00 a.m., the facility's Administrator said that Resident #1 and his spouse recently moved in to the facility. The family had a ring camera in the room so based on the ring camera provided the last time he was seen was when Staff A took Resident #1 in his room around 8:00 p.m. and then the next time was around 5:45 a.m. when he was found. When the staff took him to the room, he was wearing all his clothes. When he was found he was by the closet laying on the floor and he was wearing a pair of shorts he had removed his shirt. The Administrator said Staff A told her Resident #1's wife told her not to touch her husband and left the room but she never returned to check on him. The Administrator said the expectation was for the staff to check on residents every 4 to 6 hours, but since the incident it is more frequent. It is every two hours. The administrator said the staff does not document the observation. During an interview on at 10:03 a.m., Staff B said Resident #1 was and needed assistance to go in to bed.. He would have not been able to get to bed by himself. He said he was to check residents every 2 hours, but he did not document the observations. During an interview on at 10:13 a.m., Staff C said he was on the end of his shift when he observed resident #1 and his spouse siting in the common area with their son having ice scream. He said Staff A was supposed to take them to bed. He said Resident #1 was unable to undress himself and needed assistant to go to bed. He said they were supposed to check residents every 2 hours, but they do not document. During an interview on at 10:26 a.m.,	A 025		

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A 025	Continued From page 4 Staff D said she was the one that found Resident #1 that morning. She said it was 5:45 a.m. she did not recall the exact time. She said that he was on the floor by the closet, facing down position. He was wearing a pair of shorts, no shirt. She notified the Managers and Hospice immediately. Staff D said Resident #1 was not able to get to bed by himself, he needed assistance. Staff D said they are checking on residents every 2 hours, but they do not document observation. Staff D said Staff A told them that the residents wife told her to leave the room and not to touch her husband. During an telephone interview on at 11:00 a.m., Resident #1's son they had a camera in Resident#1's room and based on the time stamp the last time a staff was in the room was on at 8:03 p.m. and the next time was on a at 5:51 a.m. Resident #1's son said the hospice representative told them his father passed of a issue. Video Footage reviewed showed Staff A was seeing providing care on at 8:03 p.m. and leaving the room and leaving Resident #1 in his wheelchair. Next footage indicated Staff D in the room on at 5:51 a.m. Class III	A 025		