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
	AL11910533	A. BUILDING: _____ B. WING _____	R 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PHILLIPPI CREEK	5501 SWIFT ROAD SARASOTA, FL 34231

(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 revisit survey was conducted from [redacted] through [redacted] at Brookdale Phillippi Creek, an assisted living facility in Sarasota, Florida. The following deficiencies remain uncorrected A0025 Resident Care - Supervision and A0165 Risk Management and Quality Assurance - Adverse Incident Report.	{A 000}		
{A 025}	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 [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] or [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 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.	{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 (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, and interview, the facility failed to update one of three resident records reviewed (Resident #11) when she experienced a significant change in her health status after a . The findings included: 1. A review of Resident #11's incident report showed she had an unwitnessed on . . . . The incident report showed the type of injuries	{A 025}		

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{A 025}	Continued From page 2 she received were " . . ., Cut/. . . . . , Injury, Redness, . . ,," The body parts that were , . . . were " . . . (Right), Lower / , , / , ," She was sent to the emergency room for treatment. A review of the progress note in Resident #11's record dated showed she was found on the floor in her restroom. She had a "lemon size lump on her forehead with scant ." There were several progress notes that showed she was still in the hospital. Interviews were conducted with the district director of clinical services and the wellness director on at 10:45 a.m. They both said they believe Resident #11 is in a rehabilitation facility now. They did not know when she was released from the hospital, what the extent of her injuries were from the and what type of rehab she is doing. Both facility staff reviewed Resident #11's progress notes and agreed there is no other documentation concerning her , injuries or any other changes. They verified the resident was on bedhold and was expected to be returning to the facility. There is no documentation in Resident #11's record to show the significant change to her condition she experienced from this from two weeks prior. Class III .	{A 025}		
{A 165}	429.23(&) FS; 59A-36.016 FAC Risk Mgrnt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and	{A 165}		

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{A 165}	Continued From page 3 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 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	{A 165}		

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{A 165}	Continued From page 4 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. 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.	{A 165}		

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{A 165}	Continued From page 5 (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. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to report within 1 business day after the occurrence of an adverse incident, a preliminary report and provide within 15 days a full report including investigation of the incident to the Agency for Healthcare Administration (AHCA) for 2 residents (Resident #11 and #12) of 3 residents surveyed for with injury and transfer to more acute care. The findings included: 1. A review of an incident report on Resident #11 showed she had a on that resulted in	{A 165}		

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{A 165}	Continued From page 6 her going to the hospital with injuries to her right , lower , and , . Resident #11 has not returned to the facility as of yet. A review of the progress note in Resident #11's record dated showed she was found on the floor in her restroom. She had a "lemon size lump on her forehead with scant ." There were several progress notes that showed she was still in the hospital. Interviews were conducted with the wellness director and the district director of clinical services at 10:45 a.m. on . They both agreed Resident #11 was sent to the hospital with injuries due to this and now is spending time in a rehabilitation center for strengthening. She has not returned to this facility since this 2 weeks ago. They both said an adverse incident report was not completed on Resident #11 concerning this with injuries. 2. A review of an incident report showed Resident #12 had a on . This was an unwitnessed . She had an injury to her right , and was sent to hospital. Resident #12's progress note dated was reviewed. She said she slipped and . She said "her right and , hurt really bad and is unable to move right ." She was transferred to the hospital on . On she was sent to a rehabilitation center after surgery from a , . She returned to facility in . A review of the adverse incident day one shows it was not done until 8 days after the incident and then submitted to the Agency For Health Care Administration on . There was no documentation a 15-day adverse incident report was completed.	{A 165}		

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{A 165}	Continued From page 7 Interviews were conducted with the wellness director and the district director of clinical services on [redacted] at 10:45 a.m. They could not explain why this adverse incident report was not submitted within 1 business day of the incident and there was no 15 day report. Class III .	{A 165}		