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 _____	01/15/2026

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

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A 000	Initial Comments A complaint investigation #2025016640, #2025017527, #202518738, #2025018860 was conducted at Brookdale Phillippi Creek on through . Deficiencies were identified at the time of the survey.	A 000		
A 028 SS=D	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide assistance with activities of daily living as needed by each resident by failing to respond to the call system in a timely manner for 2 of (Resident #2 and #10) of 4 residents sampled. As a result, 1 Resident (#2) of the 4 sampled for call response incurred an -related . The findings included: On review of the facility's policy titled "Resident Call System and Door Alarm Response - SE-14, effective , last revised , . . . revealed the Policy Detail which included: . . . "B. Responding to resident call system alert. . . a. When an associate receives a resident call system alert, he or she should respond in a timely manner." b. If the associate is unable to respond in a timely	A 028		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 028	Continued From page 1 manner, he or she should request assistance from another associate." In an interview on at 2:30 p.m., the Health & Wellness Director described a timely manner for call system response was "within 15 to 20 minutes." On review of the facility's "Activities of Daily Living (ADL) Care Documentation Policy - AZ-19, effective , last revised , revealed, "Policy Overview It is the expectation that the activities of daily living (ADL) care outlined on the resident's service plan will be delivered as scheduled . . ." 1. In an interview on at 9:38 a.m., Resident #2 was asked about the call button response. The resident said, "They never come." She later added, "if they come, I'll be shocked. One day I called for over an hour. They never came." When asked about assistance with toileting, the resident said, "My bottom, it's because I sit on my bottom so much. I urinate on a , or brief, so that doesn't help." The home health nurse came yesterday, took some pictures, and put some cream on." On at 9:40 a.m., the surveyor observed Resident #2 push the call button. At 10:15 a.m., there was no response, 35 minutes after activating the call button. On review of Resident #2's Service Plan revealed: Focus: Bathroom Assistance date initiated: , Intervention: Resident is unable to use the bathroom on their own and requires assistance. Examples include pulling up/down pants, handling toilet paper, wiping, changing	A 028		

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A 028	Continued From page 2 protective undergarments and getting onto/off toilet. Focus: , date initiated: , Intervention: Resident needs additional help because of uncontained . Examples may include washing/cleaning up (includes showering) after accidents, changing clothes, laundering soiled clothes/linens. In a phone interview on at 5:17 p.m., the daughter of Resident #2 said the Resident told her the staff had put 2 or 3 pull-ups on her. The daughter said the home health nurse also reported finding multiple pull-ups on the Resident. In an interview on at 2:25 p.m., the Health & Wellness Director confirmed Resident #2 had a on her bottom and home health was scheduled. 2. In an interview on at 10:46 a.m., Resident #10 said, "They don't answer the [call] lights." Resident #10 said, "I on the floor and called for help [with the call button]. It was 20 minutes before they came." On at 10:47 a.m., the surveyor observed Resident #10 press the call button. At 11:13 a.m., there was no response, 27 minutes after activating the call button.. The resident had to leave to go to lunch. Class III .	A 028		
A 032 SS=E	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007	A 032		

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A 032	Continued From page 3 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures	A 032		

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A 032	Continued From page 4 for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to engage elopement prevention strategies as demonstrated the lack of identification for 2 (Residents #7 and #12) of residents documented as elopement risk on the Health Facility Assessment out of the 4 residents sampled for elopement. Staff identified 2 (Residents #6 and #7) of the 4 residents sampled for elopement who had a history of trying to go out the door but did not have on identification . Further based on interview, and record review, the facility failed to adequately document the required elopement drills by not identifying the dates or times of the drills, nor the names of staff in attendance. The findings included:	A 032		

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A 032	Continued From page 5 On review of the facility's "Elopement Risk Policy - FL-4, effective , last revised , . . . revealed Policy Detail which included: . . . 2.a. Residents assessed at risk for elopement or with any history of elopement should have identification on their persons that includes their name and the community name, address, and telephone number. . . 4. The risk of elopement will be identified in the resident's service plan." 1. In an interview on at 2:55 p.m., Care Partner Staff E said Resident #7 sometimes tries to go out the door. Record review on revealed Resident #7's Resident Health Assessment Form 1823 signed with notation Elopement Risk: "Yes". Observations on at 2:57 p.m. and at 12:27 p.m. found Resident #7 was not wearing an ID wristband. In an interview on at 3:08 p.m., Care Partner Staff F said "[Resident #6] tried to leave when she first got here, but now she just ." Record review on revealed Resident #6's Resident Health Assessment Form 1823 signed with Elopement Risk marked "No". Elopement risk was not noted on the resident's Service Plan. Observations on at 3:10 p.m. and at 12:26 p.m. found Resident #6 was not wearing an ID . Record review on revealed Resident #11's Resident Health Assessment Form 1823 signed with Special Precautions: ; Elopement Risk marked "Yes".	A 032		

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A 032	Continued From page 6 Observations on at 3:40 p.m. found Resident #11 was wearing an ID wristband with name and address of the facility. Record review on revealed Resident #12's Resident Health Assessment Form 1823 signed with Elopement Risk marked "Yes". Observations on at 2:12 p.m. found Resident #12 was not wearing an ID wristband. 2. On record review of 2025 Elopement Drills revealed documentation as: On entered at 7:10 a.m. for [no date] 1st shift elopement drill, no attendees noted. On entered at 7:15 a.m. for [no date] 1st shift elopement drill, no attendees noted. On entered at 9:02 a.m. for at 10:00 am elopement drill, no attendees noted. On entered at 1:13 p.m. for [no date] 2nd shift elopement drill, 2 illegible attendee signatures. On entered at 7:23 a.m. for [no time or shift] elopement drill, 3 signatures. Only 5 attendees were noted and 2 of the 5 attendee signatures are legible. Either the day or time of each drill is missing. In an interview on at about 9:30 p.m., the Maintenance Director acknowledged he could not decipher the signatures as to who attended the drills. Class III .	A 032		
A 120 SS=D	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17	A 120		

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A 120	Continued From page 7 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain accurate business records for checks received and to use written accounting procedures for 1 (Resident #2) of 3 residents sampled for invoices and payment. The facility had issued a 45-day notice for non-payment. After the 45-day notice was not acted upon and had expired, the facility destroyed attempted payments for Resident #2's care. The findings included: On , review of invoices for Resident #2	A 120		

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A 120	Continued From page 8 showed the invoice with no payments made and a Total Amount Due of $29,994.20. The invoice showed no payments made and a Total Amount Due of $36,493.72. The invoice showed no payments made and a Total Amount Due of $42,211.22. It would appear that payments were not being made for Resident #2. On , review of e-mails from Resident #2's daughter/power of attorney (POA) revealed: An e-mail dated , , and addressed to the Executive Director alone or with another individual questioning added personal services charges with no response from the facility. An e-mails dated and from Resident #2's daughter/POA to executive director stating she is locked out of the payment portal. An e-mail dated from Resident #2's daughter/POA to 3 Brookdale staff documenting receipt of 12 envelopes mailed to directly to Resident #2, reminding the facility to send mail to the Resident #2's daughter/POA and that she is still locked out of the payment portal. In an interview on about 2:30 p.m., the Administrator said there was no one in the facility with a 45-day notice. In a phone interview on at 5:17 p.m., the daughter/power of attorney (POA) of Resident #2 said when her checks to the facility did not clear, she asked why and was told the checks were shredded. On , review of a copy of Resident #2's daughter's check register showed two checks to Brookdale dated that did not clear.	A 120		

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A 120	Continued From page 9 In a phone interview on at 1:20 p.m., the Administrator was asked about checks for Resident #2 being shredded, he responded "That did happen." He said it was documented in an e-mail. He explained that they did not accept checks after a 45-day notice had been issued. When asked if there was a written practice or policy ˬ refusal of payments, he said he was sure there was one. On review of a letter dated from Executive Director "via Delivery" to Resident #2 and sent to daughter/POA via certified mail. "This letter as our official Discharge Notice for [Resident #2] from Brookdale Phillippi Creek for failure to pay fees and charges ..." This 45-day notice expired . On , review of an email from the Administrator "concerning taking partial payments on residents that owe monies and are on notice: [excerpt from Florida Statute 83.56(5)(a).]" The statue addresses termination of the rental agreement. However, the 45-day notice had expired . Class III .	A 120		