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
	AL11964969	A. BUILDING: _____ B. WING _____	C 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CANOPY OAKS	9070 SW 80TH AVE OCALA, FL 34481

(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 complaint survey (complaint number 2026003572, was conducted at Brookdale Canopy Oaks on March 11, 2026. Deficient practice was identified at the time of the visit.	A 000		
A 165	429.23(1-4 & 6-10) 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. Death; 2. Brain or spinal damage; 3. Permanent disfigurement; 4. Fracture or dislocation 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	A 165		

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A 165	Continued From page 1 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) Abuse, neglect, or exploitation 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	A 165		

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A 165	Continued From page 2 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 ensure the facility's Incident Reporting Policy was implemented for 1 of 3 residents, Resident #1. Findings include: Review of Resident #1's facility record a progress note dated 02/12/26 read, "Transfer Out Date/Time: 2/12/26 11:13 AM; Hospital Name: [name of local hospital]; Transport Mode: EMS [Emergency Medical Service]; Observations/Notes/Notifications: Resident right arm is swollen and red. Husband notified. Hospice notified. HWC [Health and Wellness Coordinator, name of staff] aware." Review of a progress note dated 02/12/26 at 21:26 [9:26 PM] read, "Informed that a proximal	A 165		

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A 165	Continued From page 3 left humerus fx [fracture] was identified at the ER [Emergency Room]. Decision was made to do surgical repair on 02/16/2026." Review of the facility's incident reports for the period of 2/12/2026 to 2/19/2026 did not provide a facility incident report related to Resident #1's diagnosis of a fracture to the proximal left humerus and hospitalization. During an interview on 03/11/26 at 12:05 PM, the Administrator stated, "It wasn't put in as an incident report because it wasn't a fall. This was an injury of unknown origin. There should have been one after [she went to the hospital]." Review of the facility's Incident Reporting Policy dated January 2024 read, "In the event that a resident or visitor experiences an occurrence such as, but not limited to: fall; vehicular transportation incident; resident unaccounted for; elopement; alleged aggressive behavior, abuse, neglect or exploitation; medication error; choking; scalding; fire in resident's apartment; suicide, attempted suicide or suicide ideation; and/or injury of unknown origin; the associate reporting the incident along with the supervisor or management representative, must either complete the Preliminary Draft Notes of a Reported Incident ("Draft Incident Notes") or enter the incident into the BAIRS [Brookdale Adverse Incident Reporting System] during the shift on the day of the incident." Class III	A 165		