STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Palmer Ranch Snf	5111 Palmer Ranch Parkway Sarasota, FL 34238

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44824 Based on observation, staff interview and record review, the facility failed to prevent neglect through lack of adequate assessments and supervision for a confused resident to prevent elopement from the facility for 2 (Resident #5 and #6) of 3 residents reviewed. The lack of supervision contributed to the elopement of Resident #5 and the incorrect assessment of Resident #6 who was confused and mobile via wheelchair. The findings included: Facility policy provided by the DON (Director of Nursing) for Elopement Risk with effective date of 03/2008 and last revision date of 10/2022 was defined as a situation in which a resident leaves the premises or a safe area without the community's knowledge and supervision which may represent a risk to the resident's health and safety. Evaluating for elopement risk prior to admission. Admission associate should identify potential risk for elopement and notify the Director of Clinical Services/designee of the following: The resident has a pertinent diagnosis of dementia, Alzheimer's/anxiety disorder, delusions and is the resident currently capable of independent mobility; A history of exit seeking, wandering away, or getting lost; A history of unmet needs, alcohol or drug abuse. Resident #5 was admitted to the facility on [DATE]. His diagnosis included Peripheral Vascular Disease, Hyperlipidemia, Chronic Obstructive Pulmonary Disease, Heart Disease, Congestive Heart Failure, Stroke, and Diabetes. His BIMS (Brief Interview for Mental Status) score was assessed as a 3 upon arrival which is indicative of severe cognitive impairment. His initial elopement assessment completed upon admission did not deem him an elopement risk. On 2/22/2025 Resident #5 was found outside in front of the facility in the grass after passerby's reported to the facility. He was confused and unable to verbalize why he was outside. The only injury was an abrasion to the left elbow, but the elopement had the potential for serious injury if Resident #5 had not been promptly located. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility investigation included: Physical evaluation of resident #5; Notification of health care provider of the change of condition and obtained order for wanderguard; notification of Power of Attorney (POA); Notification of DCF (Department of children and families); staffing interviews completed; Visitor log reviewed; Reviewed all residents with BIMS 12 and under and could ambulate for elopement risk (no further residents were identified); Resident's medical record and care plan revised; Resident #5 was interviewed; care plan reviewed and updated; BIMS reevaluated on 2/23/25 with new score of 11 which indicated moderate cognitive impairment; a nicotine patch was added as it was determined resident was smoking cigarettes prior to the hospital admission; impromptu QAPI initiated on 2/24/25; door checks to verify functioning correctly; daily door checks by maintenance; elopement drills; re-education to all skilled nursing staff including elopement and reporting deviation of routines for cognitive impaired residents. In an interview with the facility Administrator, she said Resident #5 was excluded from being an elopement risk upon admission because he was very confused with a BIMS score of 3 and was unable to ambulate. She said he also had no signs of being a flight risk. She said his cognition and mobility improved quickly with therapy and by the time of his elopement he was ambulatory, and his BIMS had improved to 11 which indicated moderate cognitive impairment. Resident #6 was admitted on [DATE]. She had a BIMS score of 6 which indicated severe cognitive impairment. Her admitting diagnosis included Acute Kidney Failure, Pyelonephritis, Lumbar Compression Fracture, Dementia, Cognitive communication Deficit, Diabetes, Repeated Falls. Her Quarterly Assessment was completed on 3/7/2025 and was deemed an elopement risk by the ADON (Assistant Director of Nursing). As of 3/19/2025 no care plan identifying resident as an elopement risk had been updated; no Physician order for a wanderguard had been received; Resident #6 had not been equipped with a wanderguard; and the elopement books located at reception and the nurses' station had not been updated to include Resident #6. On 03/18/2025 at 12:00 p.m., the ADON said she believed she had received recent elopement training but could not provide a date. She said a resident is at risk for elopement if they have dementia or exit seeking behavior. When asked if a resident needs a wanderguard who is confused and can self-move around the facility in a wheelchair, she said they also need a diagnosis of dementia and exiting behavior. On 03/18/2025 at 1:54 p.m., Resident #6 observed not in their room. The resident's roommate said Resident #6 is never in their room and is always out and about. On 03/19/2025 at 1:51 p.m., Resident #6 was observed in the activities room with no wanderguard device on. On 3/18/2025 at 2:05 p.m., Staff F, Certified Nursing Assistant (CNA), who has worked at the facility for 6 months, was interviewed. She said Resident #6's son took her out to dinner. She said the resident communicates her needs well. She said she has never exhibited any wandering behavior to her knowledge. Staff F said Resident #6 wanders around and visits her friends in her wheelchair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/19/2025 at 2:25 p.m., the Quality Improvement Nurse said elopement risk is completed on admission, quarterly and when there is a change in condition. When she was shown Resident #6 elopement risk assessment, she said she does not know why she would put that. When asked how long it should take to implement elopement prevention measures after someone is deemed an elopement risk, she said it should be done the same day. On 03/19/2025 at 3:04 p.m., the ADON said she made a clerical error when completing the elopement risk assessment for Resident #6. She said the alcohol section and elopement section were an error. When asked how it happened, she said I think I was just clicking fast. She said the form was never completed. When shown the completed form, she said she does not believe Resident #6 was an elopement risk and just put a new elopement risk assessment in the chart. When asked how Resident #6 was not deemed an elopement risk anymore she said she hadn't tried to leave and is not ambulatory. Facility elopement policy shown to ADON where it says, the resident has a pertinent diagnosis of dementia, Alzheimer's/anxiety disorder, delusions and is currently capable of independent mobility. When asked if the resident is capable of independent mobility, she said the resident can go short distances in her wheelchair. She said the resident shuffles her feet to move. She said it was a clerical error on her part. Resident #6 was never included in the elopement reassessments completed as part of investigation after the elopement of Resident #5.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on record review and interviews, the facility failed to ensure that the resident receives pain management services based on the resident's goals and preferences for 1 resident (#1). The findings include: Review of the policy titled Admission Data Collection and Orders last revised on 10/24 stated that the Nursing department is responsible for recording specific clinical data in the medical record upon a resident's admission to the community. The charge nurse should contact the attending physician after the resident has been admitted to the community and resident data is collected including orders should be reviewed with the physician and verified. The designated pharmacy should be notified of the new admission and order confirmation of pharmacy supplied items. Resident #1 was admitted to the facility on [DATE] at 6:30 p.m. from an acute care hospital following joint replacement surgery. Resident #1 had right knee replacement surgery and admission diagnosis of Heart Failure, Cardiomyopathy and Type 2 diabetes. The discharging orders from the hospital included Tramadol 50 milligrams (mg) 1 tablet every 6 hours as needed for pain. Based on clinical records Resident #1 was transferred to the acute care hospital on 2/10/25 at 12:30 a.m., for uncontrolled pain. The clinical record lacked documentation that showed the Resident's hospital discharge orders were reconciled with the attending physician, and that the designated pharmacy was notified of the resident's new admission. Record review of the resident's Medication Administration Record (MAR) failed to show that the hospital discharge medications were transcribed including the Tramadol. Review of the transfer form revealed on 2/10/24 at 12:30 a.m. the nurse entered a pain score of 10/10 which indicates that the resident was in severe pain and the resident requested to go to the emergency room and refused provided medications. Review of the par level of the facility's emergency medication kit included 2 tablets of Tramadol. On 3/17/25 at 12:40 p.m., during an interview Staff #A, Licensed Practical Nurse (LPN), who works overnight shift, stated that she has never had access to the medication machine, and she has worked at the facility several times. She also stated, I don't know what the process is for calling the pharmacy, if the medication is not available. On 3/18/25 at 12:45 p.m., an interview with the Director of Nursing (DON) who stated that she was unable to comment on what medication the nurse offered the resident during the time of admission based on the documentation she was reviewing but would guess it was the Tramadol. On 3/18 25 and 1:28 p.m., an interview with the Administrator who stated that off hour's shifts can order medications from the consulting pharmacist and have the medications placed into the medication dispensing machine. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 2:50 p.m., in concurrent interview, the Consulting Pharmacist said, If the hospital sends a script and, then the nurse would put the order in the EHR, I would see it. I don't see an order, so I am not seeing that they had a script for the nurse to pull the medication from the med machine. We need a hard script, and we need an electronic prior authorization (EPA) and then the nurse will get authorization to pull the first dose. On 3/19/25 at 1:35 p.m., an interview with Staff E who stated that medication order needs to be put in the EHR to reflect on the MAR. If it is not on the MAR then absolutely not, I wouldn't give it, it is not discretionary, especially narcotics.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on record review and interview the facility failed ensure to obtain physician ordered medications in a timely manner for newly admitted residents for 2 (#1 and #2) of 3 residents reviewed. The findings included: Review of the policy titled Admission Data Collection and Orders last revised on 10/24 stated that the Nursing department is responsible for recording specific clinical data in the medical record upon a resident's admission to the community . The charge nurse who admits the resident is responsible for completing the Nursing Admission Data Collection, verifying orders are present for admission, additional corresponding data collection, and reviewing the information sent by the discharging community, hospital and/or attending physician . The charge nurse should contact the attending physician after the resident has been admitted to the community and resident data is collected including orders should be reviewed with the physician and verified. The designated pharmacy should be notified of the new admission and order confirmation of pharmacy supplied items. Resident #1 was admitted to the facility on [DATE] at 6:30 p.m. from an acute care hospital following joint replacement surgery. Resident #1 had right knee replacement surgery and admission diagnosis of Heart Failure, Cardiomyopathy and Type 2 diabetes. The discharging orders from the hospital included Tramadol 50 milligrams (mg) 1 tablet every 6 hours as needed for pain. Based on clinical records Resident #1 was transferred to the acute care hospital on 2/10/25 at 12:30 a.m., for uncontrolled pain. On 2/9/24 at 11:00 p.m., an order was initiated for Resident #1 for Pain Observation and Non-Pharmacological Interventions. The clinical record lacked documentation that showed the Resident's discharge order were reconciled with the attending physician, and the designated pharmacy was notified of the resident's new admission. Record review of Resident #1's Medication Administration Record (MAR) failed to show that the hospital discharge medications were transcribed at the facility including the Tramadol. Review of the transfer form revealed on 2/10/24 at 12:30 a.m. the nurse entered a pain score of 10/10 which indicates that the resident was in severe pain and the resident requested to go to the emergency room and refused provided medications. Review of the par level of the facility's emergency medication kit documented inclusion of 2 tablets of Tramadol. On 3/17/25 at 12:40 p.m., during an interview Staff #A, Licensed Practical Nurse (LPN), who works overnight shift, stated that she has never had access to the medication machine, and she has worked at the facility several times. She also stated, I don't know what the process is for calling the pharmacy, if the medication is not available. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25 at 12:45 p.m., the Director of Nursing (DON) verified that there was no nursing assessment documented for Resident #1. On 3/18/25 at 12:50 p.m., Staff D stated that the facility expectation is that during off hours, or evening shifts, the admission orders are supposed to be placed in the Electronic Health Record (EHR) and verified, and then a re-verification is to be done the next morning. On 3/18 25 and 1:28 p.m., an interview with the Administrator who stated that off hour's shifts can order medications from the consulting pharmacist and have the medications placed into the medication dispensing machine. On 3/18/25 at 2:50 p.m., in concurrent interview, the Consulting Pharmacist said, If the hospital sends a script and, then the nurse would put the order in the EHR, I would see it. I don't see an order, so I am not seeing that they had a script for the nurse to pull the medication from the med machine. We need a hard script, and we need an electronic prior authorization (EPA) and then the nurse will get authorization to pull the first dose. On 3/18/25 at 2:50 p.m., the Regional Director of Clinical Services verified that based on review of the clinical record for Resident #1 the orders on the MAR did not include Tramadol. On 3/19/25 at 9:43 a.m., interview and record review with the Regional Nurse who verified that Tramadol for Resident #1 was not delivered to the facility until after the resident was discharged . On 3/19/25 at 1:35 p.m., an interview with Staff E who stated that medication order needs to be put in the EHR to reflect on the MAR. If it is not on the MAR then absolutely not, I wouldn't give it, it is not discretionary, especially narcotics. Resident #2 was admitted to the facility on [DATE] at 9:00 p.m. with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) with acute lower respiratory infection. The resident was discharged from the hospital with a prescription for Cefepime Injectable IV (intravenous antibiotic) 2 grams Intravenously every 6 hours. On 3/17/25 at 9:50 a.m., interview with Resident #2 who stated that upon admission, it was chaos, my medication went to the wrong place, but they straightened it out the next day. Record review of the order for Cefepime entered by the physician showed that Cefepime IV was ordered prior to arrival to the facility, and to be given at 6:00 a.m., 2:00 p.m. and 10:00 p.m. On 3/11/25 at 10:00 p.m. Cefepime dose is not verified by record review. On 3/12/25 at 6:00 a.m., record review showed the nurse entered progress note that said Med not available in Omnicell. MD made aware per report. On 3/18/25 at 11:25 a.m., an interview with Staff #D who stated that the resident received his first dose of antibiotics at 2:00 p.m. on 2/12/25 and that the facility expectation is to either obtain the medication from the Medication Administration Machine or contact the physician to obtain an order for an alternative. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25 at 1:30 p.m., the DON verified that the Cefepime order was received on 3/12/25 at 12:41 a.m. and was delivered to the facility at 1:50 p.m. on 3/12/25. The DON would not comment on whether or not the resident should have received the 2 missing doses of the medication because she had not been employed at the time. On 3/19/25 at 2:00 p.m., record review of the facility's medication inventory list the facility does not stock Cefepime 2 grams in house. The Regional nurse verified that the resident would have had to wait for the shipment to be delivered in order to receive a dose.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on record review and interviews, the facility failed to maintain complete and accurate medical records for 2 of 3 (#1 and #2) residents reviewed. The findings included: The facility policy Admission Data Collection and Orders dated 12/08 last revised 10/24 stated that the nursing department is responsible for recording specific clinical data in the medical record upon the residents admission to the community. The charge nurse who admits the resident is responsible for completing the nursing admission data collection, verifying orders are present for admission, additional data collection and reviewing information sent by the discharging community, hospital or attending physician. Resident #1 was admitted to the facility on [DATE] at 6:30 p.m. for aftercare following joint replacement surgery. The hospital discharge records include physician orders for pain medication, insulin, aftercare of incision instructions, proper positioning while in bed, weight baring status, activity orders, and equipment. Record review showed there was no nursing admission data collection filed, including admission details, cognition, communication preferences, skin issues, systems review, falls assessment, elopement risk assessment, and patient medication orders. Record review of Resident #1 showed that resident was discharged from the facility with uncontrolled pain measuring 10 out of 10 on 2/10/24 at 12:30 a.m. On 3/17/25 at 2:00 p.m., during an interview the Medical Records Director stated that the facility does not have a physical chart or paperwork on file for Resident #1, the only records of her being in the facility is what is in the Electronic Health Record (EHR). On 3/19/25 at 9:43 a.m., during an interview the Regional Nurse stated that she cannot attest to the care that the resident received while in the facility because there's nothing that I can see other than vitals and a pain score of 10 out of 10 entered at 12:00 a.m. on 2/10/24. Record review for Resident #1 shows there is no time of admission, admission assessment, physician communication note or medication verification. On 3/17/25 at 12:40 p.m., during an interview Staff A, Licensed Practical Nurse (LPN) stated that she has worked in the facility multiple times as agency staff and has had to rely on facility staff to help her with her assignment because the facility does not provide access to the medication machine. She was not aware of the process of contacting pharmacy for stat (emergent) medication orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 12:50 p.m., during an interview Staff C, LPN stated that he had not received an admission protocol, and he is limited to what he is able to document because he doesn't have access to the desktop computers at the facility to do a full admission and thank God I didn't get an admission today. On 3/18/25 at 9:15 a.m., the Director of Operations said in interview that all staff are given access to computers on the med cart, but separate access has to be given to the desktop computers. On 3/18/25 at 11:25 a.m., during an interview Staff #D stated if the resident is admitted off hours, it is still the facility's expectation that the admission checklist is complete, proper documentation is verified during morning meetings the following day or Monday after the weekend. On 3/18/25 at 2:30 p.m., during an interview the Director of Nursing (DON) stated that the facility expectation is for the nurse to perform an admission assessment but would not comment on whether the documentation for Resident #1 was sufficient because she was not working here at the time. Observation and record review of the admission checklist that is placed in the resident's physical chart. The checklist is a bullet point list that does not appear to be part of the permanent medical record and does not include any pertinent resident information. On 3/18/25 at 3:15 p.m., during an interview the Regional Nurse stated she would expect to see part of the admission report and communication to the Doctor in the EHR if the nurse reconciled the medication or verified the orders. Resident #2 was admitted to the facility on [DATE] with pneumonia due to pseudomonas, lung cancer, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia. On 3/17/25 at 9:50 a.m., during an interview Resident #2 stated that he did not receive his intravenous (IV) antibiotics on the day of admission and that it took time for the facility to get them. The resident stated, that's why I am here with this IV catheter in my had. Clinical record review for Resident #2 showed that the 3/11/25 at 10:00 p.m. IV antibiotic dose is not able to be verified because the nurse did not document whether or not it was given. Clinical record review for Resident #2 also showed that the 3/12/25 at 6:00 a.m. the nurse entered a progress note that said, Med not available in Omnicell. MD made aware per report. The record review showed that the 3/13/25 at 2:00 p.m. IV antibiotic dose was unverified and there was no documentation that it was given or note documenting that it was not given. Record review showed that the 3/16/25 at 6:00 a.m. IV antibiotic dose was unverified and there was no documentation that it was given or note documenting that it was not given. Record review of Resident #2's medical record does not include an admission time. On 3/18/25 at 11:25 a.m., during an interview Staff D, Registered Nurse (RN) was unable to determine the time that resident #2 was admitted to the facility, she could not determine from the medical record whether the resident missed the 10:00 p.m. dose of IV Cefepime. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 12:07 p.m. during an interview the Admissions Director stated that the only documentation she can provide about the admission time is that the ambulance driver picked up Resident #2 for transport to the facility at 8:15 p.m. on 3/11/25. On 3/11/25 at 7:15 p.m. an order for Cefepime was entered into the Facility's Electronic Health Record by the physician to be given at 6:00 a.m. 2:00 p.m. and 10:00 p.m. with an intended starting dose for 3/11/25 at 10:00 p.m. Record review of progress notes by nurse on 3/11/25 at 11:15 p.m. stated that the nurse performed an admission assessment but does not describe notification of physician for medication verification. On 3/18/25 at 2:50 p.m., during an interview the consulting pharmacist stated that for Resident #2, the orders for IV Cefepime were received from the facility on 3/12/25 at 10:41a.m. and sent stat (rush) to the facility arriving 2 hours later.