

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/21/2025
NAME OF PROVIDER OR SUPPLIER Brookdale Palmer Ranch Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 5111 Palmer Ranch Parkway Sarasota, FL 34238	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(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 - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, review of facility's policies and procedures, staff and residents interviews, the facility failed to protect residents' right to be free from abuse by willfully administering unauthorized over the counter medications with known effect of drowsiness during the night shift to 2 (Residents #800, and #825) of 5 residents reviewed. The findings included: Review of the facility's policy and procedure titled, Abuse, Neglect and Exploitation with an effective date of 7/20/2016 and last revised date of 10/22 revealed the facility, is committed to maintaining a safe environment for residents. Residents have the right to be free from abuse. and any physical or chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Review of the facility provided incidents investigations revealed on 7/10/25 the facility initiated an abuse investigation related to an allegation that a Licensed Nurse was administering everyone medications to make them sleep. The investigation noted: On 7/8/25 Licensed Practical Nurse (LPN) Staff C reported to the Director of Nursing (DON) that LPN Staff A was giving residents Melatonin to make them sleep. On 7/8/25, new bottles of Melatonin were placed in each medication cart. On 7/9/25, 54 Melatonin pills were unaccounted for from LPN Staff A's assigned medication cart. On 7/9/25 LPN Staff A denied giving residents sleep aid medications and said she had nothing to hide. On 7/9/25 LPN Staff A was suspended pending investigation. Resident #825: On 7/9/25 Receptionist Staff F provided a statement that Resident #825, has been significantly more confused. There are days he doesn't make sense and then other days he's his usual self. On 7/10/25 Receptionist Staff G provided a statement that, she has noticed a change in [Resident #825]. He is more confused that he had been. They often play cards and he seems more confused about what to do. Other days he is his usual self. On 7/14/25 LPN Staff A provided a statement that she gave [Resident #825] (brand name antihistamine) 1 time dose due to itching. She stated she had a provider order. In review of orders, [Resident #825] has not had (brand name antihistamine) ordered since 10/30/2024 (discontinue date). On 7/15/25 Certified Nursing Assistant (CNA) Staff H provided a statement that Resident #825, is more confused than usual at times. CNA Staff H worked the 2:00 p.m., to 10:00 p.m., shift. Resident #800: The investigation noted that on 7/14/25 LPN Staff A stated she administered Melatonin to Resident #800. Resident #800 does not have a current order for Melatonin. The incident investigation noted that the Social Services Director interviewed cognitively intact residents. Staff were also interviewed. Residents were reviewed for changes in routine and activities of daily living to determine potential other affected residents. Resident #999: Resident #999 provided a statement that she had her call light on and told the nurse (LPN Staff A) on Monday night that she couldn't sleep. LPN Staff A brought her a Tylenol and something to help her sleep. She said yes, it was melatonin when trying to pronounce an m-word. In review of [Resident #999]'s order summary, melatonin is not listed as an active order. Resident #900: On 7/9/25 Registered Nurse (RN) Staff E provided a statement that she was at the nursing station and overheard LPN Staff A saying she had given Benadryl and Melatonin to Resident #900. On 7/9/25 Receptionist Staff F provided a statement that some residents are more sleepy than usual. [Resident #900] and some others in the lobby that she couldn't immediately name. On 7/10/25 Certified Nursing Assistant (CNA) Staff D (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
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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 - Minimal harm or potential for actual harm Residents Affected - Some	provided a statement to the DON that on 7/7/25 she was helping showering Resident #900 and she [Resident #900] was very off balance and they had to have her in a wheelchair that day. She was out of it the whole day. CNA Staff D worked from 8:00 a.m., to 4:00 p.m. On 7/14/25 CNA Staff I provided a statement that he just got back from vacation. He stated that Resident #900 will sleep through everything and has had to wake her up for lunch and dinner. Not every day. Resident #850: On 7/10/25 CNA Staff D provided a statement that on Tuesday 7/8/25 Resident #850, was acting weird. She went with him to the doctor and he was son angry and mean. He yelled at the doctor and was saying something is wrong with me. I can't put my finger on it. The conclusion of the investigation noted that the allegation was verified. Three nurses heard LPN Staff A talking about giving Melatonin and/or Benadryl to residents. There was observed changes in resident behaviors (aggression, excessive drowsiness, decrease in activity participation). It is important to note that these observed behaviors were not daily. The days of observed behaviors correlated to the nights [LPN Staff A] worked. On 7/21/25, review of the clinical record for Resident #800 revealed a readmission date of 9/15/24. Diagnoses included dementia, anxiety, panic disorder and Bipolar disorder. Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 5/10/25 noted the resident scored 14 on the Brief Interview for Mental Status, indicating intact cognition. On 7/21/25 at 12:01 p.m., in an interview Resident #800 said she remembers that a few weeks ago she received medications that she had not received before. She could not remember what the medications was or the name of the staff who administered the medication. She said someone from the facility told her she received medications that she was not supposed to get. On 7/21/25, review of the clinical record for Resident #825 revealed an admission date of 5/23/25. Diagnoses included dementia, anxiety and history of falling. On 7/21/25, review of the clinical record for Resident #900 revealed an admission date of 6/30/25. Diagnoses included dementia, insomnia, delusional disorder and anxiety. The clinical record noted Resident #900 had severe cognitive loss and was rarely/never understood. On 7/21/25 at 8:55 a.m., in a telephone interview CNA Staff D said around 7/7/25 and 7/8/25 she noticed Resident #900 was very sleepy and just not right. She usually was able to walk. She was just laying around, sleeping, and sleeping in activities. She could not walk. I put her in a wheelchair, she was drooling. I asked (LPN Staff A) about it. She said the resident had a long night. Review of the clinical record for Resident #850 had a readmission date of 7/4/25. Diagnoses included dementia, and urinary tract infection. The clinical record noted the resident had severe cognitive impairment for daily decision making. The Discharge MDS with a target date of 6/29/25 noted Resident #850 had some difficulty in new situations making decisions regarding tasks of daily living. Resident #850 exhibited behavioral symptoms not directed toward others. On 7/21/25 at 8:55 a.m., in a telephone interview CNA Staff D said, Resident #850 is usually a very nice man. Suddenly, he would not let anyone do anything for him. I went with him to a physician appointment on 7/8/25 and he was not himself. He kept trying to get up from the wheelchair and was just mean. The same night, I overheard (LPN Staff A) at the nurse's station talking to (LPN Staff B). LPN Staff A said she was going to give (Resident #850) something for his behavior. On 7/21/25, review of the clinical record for Resident #999 revealed an admission date of 5/30/25. Diagnoses included a history of falling, obesity and fracture of the left tibia. Resident #999 was alert and oriented. On 7/21/25 at 9:30 a.m., in an interview Resident #999 said she could only recall that LPN Staff A gave her something for sleep. Review of the clinical record failed to reveal a physician's order for Benadryl. On 7/21/25 at 12:16 p.m., in an interview the DON verified the facility substantiated the allegation of abuse based on information obtained during the investigation. She said that Benadryl and Melatonin were stock medications. She did not know the exact number of residents LPN Staff A administered Melatonin or Benadryl to without orders. On 7/21/25 at 1:15 p.m., an attempt was made to conduct a telephone interview with LPN Staff A. A voicemail was left with telephone number to return the call.		