STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106022	A. BUILDING B. WING	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced complaint survey for complaint number 2025010232 was conducted on 7/21/25 at Brookdale Palmer Ranch, a nursing home in Sarasota, Florida. Brookdale Palmer Ranch is not in compliance with the Code of Federal Regulations (CFR) 42, Part 483, Requirements for Long-Term Care Facilities. The following is a description of the noncompliance.	F0000		07/25/2025
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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,	F0600	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. F: 600 How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 7/9/25 Nurse A was suspended pending investigation related to the administration of Melatonin and Benadryl. Nurse A resigned on 7/15/25. Resident 999 was evaluated by a licensed nurse on 7/11/25, and notified the Healthcare Provider (HCP), and the resident's representative of the medication error. No new orders were obtained. Resident 900 was reviewed on 7/11/25 by the Director of Clinical Services (DCS) and/or Assistant Director of Clinical Services (ADCS) for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators. The HCP and	07/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
F0600 SS = E	Continued from page 1 "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)."	F0600	Continued from page 1 resident representative were notified of the med error. No new orders were obtained. Resident 850 was reviewed on 7/11/25 by the Director of Clinical Services and/or Assistant Director of Clinical Services for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators. The HCP and resident representative were notified of the medication error. No new orders were obtained. Resident 825 was reviewed on 7/11/25 by the Director of Clinical Services and/or Assistant Director of Clinical Services for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators. The HCP and resident representative were notified of the medication error. No new orders were obtained. Resident 800 was reviewed on 7/11/25 by the Director of Clinical Services and/or Assistant Director of Clinical Services for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators. The HCP and resident representative were notified of the medication error. No new orders were obtained. How will the facility identify other residents having the potential to be affected by the same deficient practice? On 7/9/25 the DCS or designee reviewed current resident records to determine if they had physician orders for Melatonin and Benadryl. Between 7/10/25 and 7/15/25, current residents records and associate interviews were reviewed by the DCS and ADCS for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
F0600 SS = E	Continued from page 2 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 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:	F0600	Continued from page 2 On 7/15/25 current residents with a BIMS of 12 or higher were interviewed by Social Services or designee regarding medications and if they were offered sleep medications. No further residents were identified. Between 7/10/25 and 7/15/25, eight (8) family members were interviewed by the Executive Director or designee for any concerns in care, medications or changes in their loved one. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? 7/18/25 Assistant Director of Clinical Services provided re-education to licensed nurses on Melatonin and Benadryl administration, 7 rights of medication administration, physician notification on missed/refused medication, PRN medication administration, abuse and neglect. On 7/8/25 Melatonin was counted by DCS or designee. Upon further staff interviews, on 7/9/25 daily Melatonin counts expanded to all nurse carts and daily Benadryl counts were added. On 7/28/25, the DCS or designee changed the Melatonin and Benadryl from stock bottles to individual bubble cards filled through the pharmacy. Social Services and/or designee will review the Behavior Report in Daily Stand Up to assist with identification of new changes in residents behaviors that may require an additional review. How will the facility monitor its' performance to make sure that solutions are sustained? To assist with compliance, the DCS or designee has audited the count for melatonin, daily beginning on 7/8/25. The DCS or designee has audited daily the count for Benadryl beginning on 7/9/25. Daily audits continued through 7/27/25 with no discrepancies noted. Audits conducted twice a week for two weeks, then weekly for a combined total of 12 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
F0600 SS = E	Continued from page 3 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	F0600	Continued from page 3 Social Services or designee will conduct two resident interviews weekly with residents BIMS 12 or higher for 12 weeks. The Assistant Director of Clinical Services or designee will conduct one medication pass observation per week for 12 weeks. The DCS or designee will review findings of the audits monthly in the Quality Assurance Performance Improvement (QAPI) Meeting for 3 months. Discipline Responsible: The Director of Clinical Services or designee will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
F0600 SS = E	Continued from page 4 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.	F0600		

Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
N0000	INITIAL COMMENTS An unannounced complaint survey for complaint number 2025010232 was conducted on 7/21/25 at Brookdale Palmer Ranch, a nursing home in Sarasota, Florida. Deficiencies were identified at the time of the survey.	N0000		07/25/2025
N0204 SS = E	Right to be Free from Abuse, Restraints, etc CFR(s): 400.022(1)(o), FS 400.022, F.S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following: (o) The right to be free from mental and physical abuse, sexual abuse, neglect, exploitation, corporal punishment, extended involuntary seclusion, and physical abuse, corporal punishment, extended involuntary seclusion, and physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	N0204	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. N: 0204 How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 7/9/25 Nurse A was suspended pending investigation related to the administration of Melatonin and Benadryl. Nurse A resigned on 7/15/25. Resident 999 was evaluated by a licensed nurse on 7/11/25, and notified the Healthcare Provider (HCP), and the resident's representative of the medication error. No new orders were obtained. Resident 900 was reviewed on 7/11/25 by the Director of Clinical Services (DCS) and/or Assistant Director of Clinical Services (ADCS) for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators. The HCP and resident representative were notified of the med error. No new orders were obtained.	07/25/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
N0204 SS = E	Continued from page 1 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."	N0204	Continued from page 1 Resident 850 was reviewed on 7/11/25 by the Director of Clinical Services and/or Assistant Director of Clinical Services for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators. The HCP and resident representative were notified of the medication error. No new orders were obtained. Resident 825 was reviewed on 7/11/25 by the Director of Clinical Services and/or Assistant Director of Clinical Services for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators. The HCP and resident representative were notified of the medication error. No new orders were obtained. Resident 800 was reviewed on 7/11/25 by the Director of Clinical Services and/or Assistant Director of Clinical Services for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators. The HCP and resident representative were notified of the medication error. No new orders were obtained. How will the facility identify other residents having the potential to be affected by the same deficient practice? On 7/9/25 the DCS or designee reviewed current resident records to determine if they had physician orders for Melatonin and Benadryl. Between 7/10/25 and 7/15/25, current residents records and associate interviews were reviewed by the DCS and ADCS for changes in sleep patterns, drowsiness, decreased participation in activities, sudden incontinence at night, shower refusals, decrease in appetite especially at breakfast and lunch, falls, significant changes, and other indicators.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
N0204 SS = E	Continued from page 2 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 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	N0204	Continued from page 2 On 7/15/25 current residents with a BIMS of 12 or higher were interviewed by Social Services regarding medications and if they were offered sleep medications. No further residents were identified. Between 7/10/25 and 7/15/25, eight (8) family members were interviewed by the Executive Director or designee for any concerns in care, medications or changes in their loved one. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? 7/18/25 Assistant Director of Clinical Services provided re-education to licensed nurses on Melatonin and Benadryl administration, 7 rights of medication administration, physician notification on missed/refused medication, PRN medication administration, abuse and neglect. On 7/8/25 Melatonin was counted by DCS or designee. Upon further staff interviews, on 7/9/25 daily Melatonin counts expanded to all nurse carts and daily Benadryl counts were added. On 7/28/25, the DCS or designee changed the Melatonin and Benadryl from stock bottles to individual bubble cards filled through the pharmacy. Social Services and/or designee will review the Behavior Report in Daily Stand Up to assist with identification of new changes in residents behaviors that may require an additional review. How will the facility monitor its' performance to make sure that solutions are sustained? To assist with compliance, the DCS or designee has audited the count for melatonin, daily beginning on 7/8/25. The DCS or designee has audited daily the count for Benadryl beginning on 7/9/25. Daily audits continued through 7/27/25 with no discrepancies noted. Audits conducted twice a week for two weeks, then weekly for a combined total of 12 weeks. Social Services or designee will conduct two resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
N0204 SS = E	Continued from page 3 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	N0204	Continued from page 3 interviews weekly with residents BIMS 12 or higher for 12 weeks. The Assistant Director of Clinical Services or designee will conduct one medication pass observation per week for 12 weeks. The DCS or designee will review findings of the audits monthly in the Quality Assurance Performance Improvement (QAPI) Meeting for 3 months. Discipline Responsible: The Director of Clinical Services or designee will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238

(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) COMPLETION DATE
N0204 SS = E	Continued from page 4 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. Class III	N0204		

Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PALMER RANCH SNF	**5111 PALMER RANCH PARKWAY , SARASOTA, Florida, 34238**

(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) COMPLETION DATE
N0204 SS = E		N0204		