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
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 investigation (complaint numbers 2021004825 and 2021008045) and generator assessment was conducted at Forsyth House on [redacted], 2021. The facility had deficiencies at the time of the survey.	A 000		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [redacted] Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 1 proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.	A 030		

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
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 2 (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,	A 030		

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
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 3	A 030		

autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , , , , , , , , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 4 relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names	A 030		

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
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 5 and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on staff interview and record review, the facility failed to provide an appropriate 45-day notice of discharge for 1 of 1 resident (#1), and failed to include required information in the discharge notice informing the resident/family/representative to contact the State	A 030		

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
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 6 Long-Term Care Ombudsman Program for assistance with re-location including the statewide toll-free number and email address for the program for 2 of 2 residents (#1 and #2). The findings include: Upon entrance, the Executive Director (ED) was asked to provide all discharge notices issued in the past 6 months. The ED provided two 45-day notices of discharge: one to Resident #2's representative on and one to Resident #1's family member on . A record review of Resident #2's Notice to Vacate addressed to the representative and dated revealed that contact information for how to reach the State Long Term Care Ombudsman, including the statewide toll free telephone number, was not provided in the notice. A record review of Resident #1's Notice to Vacate addressed to a family member and dated revealed that the contact information for how to reach the State Long Term Care Ombudsman, including the statewide toll free telephone number, was not provided in the notices. On at 1:06 PM, an interview was conducted with the ED regarding the contents of the discharge notices. The surveyor read aloud the regulation which included the need to provide a statement that the resident can contact the State Long Term Care Ombudsman Program for assistance with re-location and must include the statewide toll free number for the program. The surveyor asked if the letter contained all of the required information. The ED confirmed that it did	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 7 not. The ED stated, "I did not know it needed to be there." The ED further stated that she would re-send the notification with the appropriate wording. A record review for Resident #1 revealed a Notice to Vacate dated with the subject line: Termination of Residency Agreement for Resident #1. The letter stated "This is notice of 45 days to vacate from Forsyth House...this is effective, as of ." Further review of the letter revealed, "Due to her ongoing increased need for alternative medical care levels of higher skilled needs, we are no longer able to provide her residency at Forsyth House or service". A record review of Resident #1's Pre-Admission Assessment Form dated revealed a current medical diagnosis of , and . A review of the behavior screen form also dated revealed no behaviors. A record review of Resident #1's Resident Health Assessment Form for Assisted Living Facilities (1823) dated revealed the following: or behavioral status alert oriented, competent to sign papers, history of and , and independent of all activities of daily living. The question, "In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or facility?" was marked as yes. The box for "Needs Assistance With Self Administration" of medications was marked as yes. A record review of Resident #1's History and Physical revealed the resident was readmitted to	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 8 the hospital on [illegible] for continued symptoms of [illegible]. Further review revealed a current legal status voluntary competent and every 15 minute checks. A review of facility progress notes revealed Resident #1 was admitted to the facility on [illegible] and was noted with the following behaviors: [illegible] "agitated until taking her medication then she calmed down"; "staff called this nurse last night due to resident not taking her medication", "out in courtyard for 2 hrs (hours) walking dog", "started acting bizarre around the dog by shaking her key and telling the dog 'let's go for a ride in the car and then putting her [illegible] in the water bowl and then putting it on the dog's [illegible] "; [illegible] "staff stating that she was calling them dirty Mexican's and that she would not take medicine"; [illegible] "aggressive towards staff", "due to being a male LPN (Licensed Practical Nurse) had difficulty administering medicine", "throwing dog food in hallway", "destroyed her room", "911 was notified and police department just in case", " (Emergency Medical Services) arrived...Resident was taken to [hospital] for evaluation"; "returned..and was still agitated", [illegible] taken to [illegible], "Resident was very loud in waiting room", [illegible] "Resident agitated on this shift. Following staff and yelling in hallway."; [illegible] refusing to take her [illegible] medication; "behavior was aggressive toward LPN"; [illegible] "had periods of being argumentative with staff and very loud"; [illegible] 4:00 PM "Resident stated she wanted to go to hospital due to having 4+ pitting [illegible] in left [illegible] and chills all over. So when ambulance arrived resident refused to go"; 10:20 PM "resident had called the law numerous times stated we were beating her and her dog",	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 9 "Resident stated we were cutting her with a knife on her ", "sheriff's office was here along with the ambulance", "Resident was taken to [hospital] for behavioral issues"; Resident continued to have behaviors through . . . . . On "Resident stated someone came in her room Saturday night and beat her up"; "Resident screaming and yelling"; . . . . . "screaming at staff...clenched fist banging on residents doors, following staff...called 911 - . . arrived...city police/ - assessed resident and deemed transport for . . . . appropriate"; . . . . . returned to facility; "verbally aggressive", "Resident attempted to call 911", "911 sent 2 officers to handle resident", "Resident continued to shout at officers and staff"; . . . . . "called 911 herself demanding they come get her", "getting louder and louder with her cussing so 911 was called to have resident sent to [hospital] for her behaviors"; . . . . . "Resident remains in hospital". A record review of Resident Contract Agreement Article V Term, Transfer, and Termination revealed in Section C that "The Community may terminate this Residency Agreement upon _____ (per state requirement) days written notice delivered to you and, if applicable, your Representative and Responsible Party, at the address(es) provided." Subsection 1 revealed, "As permitted by the State Administrative Code, nothing in the above section prevents the immediate discharge from the premises, with or without notice, of a resident who is combative, violent, ... or . . . . . , or otherwise a danger to himself or others. You, your Representative, and your Responsible Party agree to notify the community in writing immediately upon obtaining knowledge that the Resident has experienced any one of these	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 10 conditions or behaviors. Subsection 2 revealed, "The Community may immediately terminate this Residency Agreement for the following reasons: a. Medical. Due to changes in your physical or mental condition, supplies, services, or procedures are required which extend beyond the certification, licensure, design, or staffing of the Community. b. Resident's Welfare. Termination is necessary to protect your safety, health, or welfare. C. Welfare of Others. Your continued residency in the Community endangers the safety, health, or welfare of others. d. Transfer to Another Community. You permanently transfer to another assisted living community or nursing home. e. Failure to Abide by the Rules. You fail to observe and abide by the Community's rules and policies. f. Contract Violation. You fail to meet your contractual ˘ under this Residency Agreement. g. Interference with Quiet Enjoyment of Others. Your conduct is disruptive or disturbing to other residents and such behavior continues after notice to you to cease such behavior. h. Cease of Operations. The Community ceases to operate or is sold to a new operator." A record review of the document "Exhibit K Resident Rights" revealed in section (k) that "At least ___ days' notice of relocation or termination of residency from the community unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given ___ days' notice of a non-emergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a community to terminate the residency of an	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 11 individual without notice as provided herein, the community shall show good cause in a court of competent jurisdiction." On at 2:34 PM, an interview was conducted with the former Executive Director (ED) who issued the discharge notice to Resident #1. The surveyor asked why Resident #1 was discharged without 45-day notice. The former ED replied that Resident #1's behavior was escalating while she was in facility, and she was numerous times. The surveyor asked why she did not start the process for 45-day notice at the time the resident started displaying behaviors. No initial response was provided. She then said, "Resident #1 went out to the hospital the last time and corporate told me I could not bring her safely to the facility." The surveyor asked for documentation that Resident #1 was not stable enough to return to the facility. The former ED said she talked to the resident on the phone while she was in the hospital and could not have a reasonable conversation with her, and the Resident Care Director had also called. The surveyor informed the former ED that no documentation of those calls could be located in the resident's closed record. The former ED stated again that she could not have a reasonable conversation with the resident while on the phone. The surveyor asked if she made notes of the calls she made and she replied, "No". The surveyor then asked if she visited Resident #1 in the hospital to assess her for return to the facility and she stated, "No, I did not assess her, only on the phone numerous times with her." The surveyor discussed that Resident #1 had a primary diagnosis of , , and , at the time of her initial admission in of 2020. She stated, "I did not know that." She stated she	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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 030	Continued From page 12 understood but the corporate person told her Resident #1 could not come . Class III	A 030		
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by:	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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
CZ814	Continued From page 13 Based on staff interview and background screening roster review, the facility failed to register 9 of 21 employees with the background screening clearinghouse maintained by the Agency (A, B, C, D, E, F, G, I and J). The findings include: A review of the background screening roster obtained from the Agency's background screening portal revealed that the roster did not contain the individuals who were observed to be in the building working on . A list of employees with job titles and dates of hire was requested upon entry. On from 1:30 PM to 2:00 PM, the list of employees and the background screening roster were reviewed with the Executive Director (ED). The list of employees revealed a total of 21. Nine of those employees were not registered with the clearinghouse according to the background screening roster. The following employees were not on the roster: A. Licensed Practical Nurse (LPN) hire date and date of birth ; B. Receptionist hire date of and date of birth ; C. LPN hire date of and date of birth ; D. Med Tech (MT) hire date and date of birth ; E. Resident Assistant ( ) hire date and date of birth ; F. /MT hire date and date of birth ; G. hire date and date of birth ;	CZ814		

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
	AL11965135	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH HOUSE	5887 BERRYHILL RD MILTON, FL 32570

(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
CZ814	Continued From page 14 I. /MT hire date and date of birth ; and J. hire date and date of birth . On at approximately 1:55 PM, the ED stated, "I knew employee A was not on the roster but was not aware all the others were not on the roster." Unclassified	CZ814		