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
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for #2023015746 was conducted on [redacted] and [redacted] at Grace Assisted Living, an assisted living facility in Port Charlotte, Florida. Complaint #2023015746 was substantiated at A030 - Resident Care and A152 - Physical Plant, Safe Living Environment, both at Class 1 severity. The following is a description of the deficiencies.	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) 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	A 030		

AHCA Form 3020-0001

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

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
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 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 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 standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (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	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
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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	A 030		

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.

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, autonomy, and interaction within the community.

(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 (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 [illegible] for health care services, the provision of or arrangement of transportation to health care [illegible], 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 [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for	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
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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	A 030		

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 and identities of the residents involved in the

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
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 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 observation, and interview, the facility failed to ensure a safe living environment for 5 (Residents's #1, #2, #3, #4, and #5) of 5 residents by restricting residents from exiting their bedrooms, and from exiting the facility in the case	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
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 of an emergency. This has the potential for serious physical harm or in the event of an emergency situation. The facility failed to promote personal dignity for 2 (Residents's #1, and #2) of 2 residents locked in their room, and locked out of their bathroom at night. The findings included: On at 11:00 p.m., while touring the facility, observed a pin inserted in the door to Bedroom #1. The pin prevents the door from opening, in order to keep the two residents in # from . All doors to the outside of the facility are locked from the inside of the facility with a key. The Emergency Exit signs are affixed above egress doors. However, the residents do not have access to the key and the doors do not have mechanisms that allow opening in the case of an emergency. The cranks have been removed from the windows in all the resident rooms making them , for emergency egress. Observed that the bathroom in Bedroom #1 was locked denying use by the occupants of the bedroom. Observed a commode chair placed in the bedroom without a privacy screen. (Photographic evidence obtained) On at 11:00 p.m., in an interview, the caregiver said she is in the facility all night. She confirmed that she does not stay awake all night. The caregiver said all the doors to the outside are locked at night from the inside with a key. She said Bedroom #1, occupied by Residents #1 and #2, is closed and latched at bedtime. The caregiver said the residents and are exit seeking, so they have to lock the door to keep the two residents from around and getting out of the facility. The caregiver said Resident #1	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 will take showers three to four times per night, and floods the bathroom floor, so they lock the bathroom to keep the resident from running the shower. She said they have a commode chair in the bedroom for use during the night. On . . . . . at 11:18 p.m., Resident #3 said he is not locked in his room. He said in case of a fire he would pull the fire alarm and go to the marked exit door to get out of the building. He said he does not know how to get out of the building when the doors are locked. He said he would try to go through the window if trapped in his room. He said without the handle he cannot open the window. On . . . . . at 9:00 a.m., in an interview, the Administrator/Owner said we locked the bathroom door in Bedroom #1 because Resident #1 is in the shower 3 or 4 times per night. The result is a high water bill and water all over the bathroom floor. The Owner said she latched the door to the bedroom as much to keep Resident #5 out of Bedroom #1 as to keep the occupants of the bedroom in. She said she blocked the glass sliding doors in Bedroom #1 with patio furniture to discourage the residents from getting out that way. The owner said the cranks for the windows were removed so residents would not leave at night, , , Resident #5. The owner said Resident #5 is always trying to get away because a female on social media is enticing him. On . . . . . at 1:50 p.m., in an interview, Resident #2 said he has thought about the door being locked if he needed to get out in an emergency. He said he would break the door down. Resident #1 said they are locked in the room all night. He said it concerns him because	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 there is no way for them to get out. Resident #1 said the bathroom is locked at night, so they have to use the commode chair in their room. He said he would rather use the toilet and be able to wash his . . . . . On . . . . . at 1:55 p.m., the County Fire Inspectors toured the facility and performed a complete inspection. They noted the facility was out of code compliance with the key locks on the two main egress doors. The facility wa out of compliance with a locking mechanism on a bedroom door that is not able to be opened by the resident. Also, the facility is out of compliance by removing the window cranks in the resident rooms. They fire inspectors said it is not a safe living environment for the residents. They said the residents in bedroom 1 were at risk of harm because there was no way for them to escape the room in an emergency. The Fire Inspectors informed the owner she must have thumb locks on the two egress doors, must fill the hole that was used to pin the bedroom door shut and must put the cranks on the windows. They said the residents must have two ways to get out of their rooms. They said the owner must be within code. On at 4:20 p.m., the Owner said she understands she cannot lock the residents in their rooms. She said she must allow the residents to use the toilets and handwashing sinks at night. She said she has to change the locking system on the emergency egress doors.	A 030		
A 152 SS=J	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must:	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 152	Continued From page 9 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, and interview, the facility failed to maintain a safe living environment free of hazards for 5 (Residents #1, #2, #3, #4, and #5)	A 152		

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
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 152	Continued From page 10 of 5 residents living at the facility. As determined by the county fire inspectors finding, the residents do not have free, unencumbered use of the building's exit doors. This poses imminent danger and a substantial probability of [redacted] or serious physical harm in the event of an emergency situation. The findings included: On [redacted] at 11:00 p.m., while touring the facility, observed a pin in the bedroom door that prevents the door from opening. This is used to keep the two residents from [redacted]. All of the doors to the outside are locked from the inside of the facility with a key. The Emergency Exit signs are affixed above the egress doors. However, the residents do not have access to the key and the doors do not have mechanisms that allow opening in an emergency. The [redacted] cranks have been removed from the windows in the resident rooms making them [redacted] for emergency egress. (Photographic evidence obtained) On [redacted] at 11:00 p.m., in an interview, the caregiver said she is in the facility all night. She confirmed that she does not stay awake all night. The caregiver said all doors to the outside are locked at night from the inside with a key. She said she has the keys with her at all times, even when in her room sleeping. She said Bedroom #1, occupied by Residents #1 and #2, is closed and latched from the outside at bedtime. The door is a pocket door and is locked shut with a metal pin placed in a hole through the door frame and through the door. This prevents the door from sliding open. The caregiver said the residents [redacted] and are exit seeking so they have to lock the door to keep the two residents from [redacted] around and getting out of the	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 152	Continued From page 11 facility. On [redacted] at 9:00 a.m., in an interview, the Administrator/Owner said the problem behaviors by Residents #1 and #2 increased in [redacted], when Resident #5 was admitted to the facility. She said Resident #5 does not want to listen to anything. He goes into Bedroom #1, wakes up the residents and gets them stirred up. The Owner said she latched the door to the bedroom as much to keep Resident #5 out of Bedroom #1 as to keep the occupants of the bedroom in. The Owner said she blocked the glass sliding doors in Bedroom #1 with patio furniture to discourage the residents from getting out that way. She said the cranks for the windows were removed so residents would not leave at night, [redacted] Resident #5. The Owner said the caregiver always has the keys to the locks with her. The owner said she has a full set of keys she always has with her. The Owner said Residents #1 & #2 were not as active prior to the admission of Resident #5. She said Resident #5 is young and does not follow rules. She said Resident #5 had a [redacted], when he was very young. She said his mental development is that of an adolescent. The owner said the resident is always trying to get away because a female on social media is enticing him. On [redacted] at 1:50 p.m., in an interview, Resident #2 said he has thought about it and if he needed to get out in an emergency. He said he would break the door down. Resident #1 said they are locked in their room all night. He said it concerns him because there is no way for them to get out. On [redacted] at 1:55 p.m., two Fire Inspectors came to the facility and completed an inspection	A 152		

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
	AL11968994	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE ASSISTED LIVING, LLC	22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954

(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 152	Continued From page 12 of the premises. They noted the facility was out of code compliance with the key locks on the two main egress doors with no way for the residents to let themselves out of the building in an emergency. The Fire Inspectors stated the facility was out of compliance by having a locking mechanism on a bedroom door that is not able to be opened by the resident. They also said the facility is out of compliance by removing the window cranks in the resident rooms. The fire inspectors said it is not a safe living environment for the residents. They said the residents in Bedroom #1 were at risk of harm because there was no way for them to escape the room in an emergency. The Fire Inspectors informed the owner she must have a lock system on the two egress doors that will open in an emergency. They said the hole that was used to pin the bedroom door shut must be filled. Also, the [redacted] cranks must be reinstalled on the windows. The Fire Inspectors said the residents must have two ways to get out of their rooms. They also pointed out that arrows were missing on some exit signs, the fire extinguisher is out of date, and an electric extension cord was improperly used. They said the owner must maintain the facility within code. The fire inspectors informed the owner that the locking mechanism on the bedroom door must be eliminated immediately. They said the locks on the two egress doors must be replaced as soon as possible. On [redacted] at 4:20 p.m., the Owner said she understands she cannot lock the residents in their rooms. She said she has to change the locking system on the emergency egress doors.	A 152		