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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 relicensure, emergency power plan, health facility reporting system, generator, visitation form, and complaint survey for #[redacted] on [redacted] through 2/13/24 at DeSoto Palms Assisted Living Community, an assisted living facility in Sarasota, Florida. Complaint #2023001532 was substantiated at A054. The following is a description of the deficiencies.	A 000		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known allergies the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and,	A 054		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 054	Continued From page 1 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical restraints, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication records contained accurate recording each time the medication is taken, any missed dosages, refusals to take medications or medication errors for 2 (Residents #11 and #14) of 2 residents reviewed. The findings included: Facility policy titled Medication-Report: Medical/Medication Error Report. No date. "It is the policy of the facility to identify, investigate, and analyses errors related to medical and medication errors in accordance with quality assurance and performance improvement goals." Definition: Medication Error is an error that includes a mistake or non-adherence of the Five R's (right resident, right medication, right does, right frequency and right route). 1. Review of the clinical record for [redacted] # an admission date of 4/7/22. The diagnoses include Cerebral Infarction due to Unspecified Occlusion or Stenosis of Unspecified Cerebral Artery. Documentation of the "Medication Observation Record" (MOR) for	A 054		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 054	Continued From page 2 January 2024, and February 2024 revealed the medication technicians documented they assisted the resident to take Eliquis (blood thinner) 2.5 mg (milligrams) one tablet twice daily and Eliquis 5mg 1 tablet twice daily. A , dated 12/21/23 at 5:47 p.m., requested "Nursing - please confirm that Resident #11 is taking Eliquis 12.5mg twice a day which was decreased by , m mg) on 11/5/23." The Eliquis 5mg dose was not removed from the MOR and continued to be signed-off as given. 2. Review of the clinical record for # an admission date of 8/20/21. The diagnoses included Acute Pain, Angina, Congestive Heart Failure. Documentation of the MOR noted, Aspirin low-dose chewable 81 mg chew and swallow one tablet by mouth at bedtime and Hydrocodone 5-325 mg, take as needed twice daily for pain. The MOR for February 2024 , m / /24, , 2/10/24, 2/11/24, or 2/12/24 as ordered by the physician. The MOR for Resident #14 noted there was no Hydrocodone administered to the resident although 4 doses were signed out of the narcotic narcotic controlled substance record for Resident #14. On 2/13/24 at 12:10 p.m., a pharmacy representative , # 's to the facility on 2/8/24. On 2/13/24 at 12:15 p.m., the Wellness Director said, "An order for Eliquis 5 mg had been discontinued back in November but staff continued to assist the resident to take the	A 054		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 054	Continued From page 3 discontinued Eliquis". The Wellness Director verified the MOR showed the staff continued to document administration of Eliquis 5 mg for Resident #11. The Wellness Director verified the lack of documentation of administration of Hydrocodone for Resident #14 was a problem and the documentation was inaccurate. Class III	A 054		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable disease. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative tuberculosis examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of tuberculosis testing materials satisfies the annual tuberculosis examination requirement. An individual with a positive tuberculosis test must submit a health care provider's statement that the individual does not constitute a risk of communicating tuberculosis. 2. If any staff member has, or is suspected of	A 078		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 078	Continued From page 4 having, a communicable disease, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable disease. (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility contracting to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff contracted by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by:	A 078		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 078	Continued From page 5 Based on record review and interview, the facility failed to ensure 1 (Staff D) of 4 staff reviewed, submitted a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable disease within 30 days of employment. This has the potential to put a vulnerable population at risk of developing communicable diseases. The findings : Resident Aide Staff D's e , e 2/13/24 indicated a hire date of 6/26/23. The file did not contain a written statement from a health care provider documenting the from signs/symptoms of communicable disease. During an interview on 2/13/24 at 11:07 a.m., the Business Office Director confirmed that no documentation of freedom from communicable disease was on file for Staff D. Class III	A 078		
A 082 SS=D	59A-36.011(4) FAC Training - HIV/AIDS (4) HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on HIV and AIDS, including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of	A 082		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	5601 N HONORE AVE SARASOTA, FL 34243

(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 082	Continued From page 6 this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 (Health and Wellness Director) of 4 staff reviewed completed the required HIV and AIDS education course within 30 days of employment. The findings included: Review of the Health and Wellness Directo 's m, . . file on 2/13/24 . . . . . date of 8/2/23. The file contained documentation of completion . . . . . HIV/AIDS training on 1/10/24, not meeting . . . meframe. During an interview on 2/13/24 at 11:22 a.m., the Business Office Director confirmed that the Health and Wellness Director's HIV/AIDS training was not completed within the required timeframe. Class III	A 082		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) ALZHEIMER'S DISEASE AND RELATED DISORDERS ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4	A 086		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 086	Continued From page 7 hours of initial training within 3 months of employment. Completion of the core training program between April 20, 1998 and July 1, 2003 shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled "Alzheimer's Disease and Related Disorders Level I Training," must address the following subject areas: 1. Understanding Alzheimer's disease and related disorders; 2. Characteristics of Alzheimer's disease; 3. Communicating with residents with Alzheimer's disease; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility Alzheimer's Disease and Related Disorders Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled "Alzheimer's Disease and Related Disorders Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Alzheimer's Disease and Related Disorders Level II Training must address the following subject areas as they apply to these disorders: 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents,	A 086		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 086	Continued From page 8 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with Alzheimer's Disease and Related Disorders," dated March 1999, incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with Alzheimer's disease or related disorders, or 2. Three years of practical experience in a	A 086		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 086	Continued From page 9 program providing care to persons with Alzheimer's disease or related disorders, or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with Alzheimer's disease or related disorders. (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure for 2 (Health and Wellness Director and Staff E) of 4 staff reviewed, completed the required 4-hour in-service training for Alzheimer's Training Level I within 3 months of hire, and for 1 (Staff E) of 4 staff reviewed complete Alzheimer's Training Level II within 9 months of hire for facilities advertising special care to residents with Alzheimer's disease and related disorders (ADRD), or who have secure areas, staff who have regular contact and/or provide direct care to residents with ADRD. This has the potential to put vulnerable populations at risk. The findings included: Health and Wellness Director's m[illegible] on 2/14/24 indicated a hire date of 8/2/23. The file showed m completion of 4-hours Alzheimer's Level I training on 1/10/24 which was not within the required 3	A 086		

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
		A. BUILDING: _____ B. WING _____	/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNITY	**5601 N HONORE AVE SARASOTA, FL 34243**

(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 086	Continued From page 10 months of hire. Review of Medication Technician Staff E's employee /14/24 indicated a hire /17/23. The file contained no documentation for completion of the 4-hour Alzheimer's Training Level I within 3 months of hire, and no documentation for completion of Alzheimer's Level II training within m hire. During an interview on 2/13/24 at 11:30 a.m., the Business Office Director confirmed that there was no documentation of completion within the required timeframe of the Alzheimer's Level I training for the Health and Wellness Director, and no documentation of completion of Alzheimer's Level I and II training for Staff E. Class III	A 086		

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
	AL11967856	A. BUILDING: _____ B. WING _____	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNI	5601 N HONORE AVE SARASOTA, FL 34243

(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	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person 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. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967856	A. BUILDING: _____ B. WING _____	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNI	5601 N HONORE AVE SARASOTA, FL 34243

(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 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; 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: Based on record review and staff interview, the facility failed to ensure 1 (Staff E) of 4 staff records reviewed, had Level 2 background screening employment status updated within 10 business days on the Agency's Background Screening Clearinghouse (Clearinghouse) website. This has the potential for staff with disqualifying offenses to have access to adults. The findings included: Record review on of the Clearinghouse Employee Roster indicated that Medication Technician Staff E was hired on and added to the roster on . During an interview on at 11:34 a.m., the Business Office Director verified they are responsible for adding employees to the Clearinghouse. They acknowledged that Staff E	CZ814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967856	A. BUILDING: _____ B. WING _____	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNI	5601 N HONORE AVE SARASOTA, FL 34243

(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 2 was not added to the Clearinghouse within the required timeframe. "Photographic evidence obtained." Unclassified	CZ814		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967856	A. BUILDING: _____ B. WING _____	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNI	5601 N HONORE AVE SARASOTA, FL 34243

(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
CZ830	Continued From page 3	CZ830		

appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.
(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the state of emergency.
2. Is currently licensed.
3. Does not have a provisional license.
4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.
(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967856	A. BUILDING: _____ B. WING _____	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNI	5601 N HONORE AVE SARASOTA, FL 34243

(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
CZ830	Continued From page 4 requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit annually and maintain documentation of a current Comprehensive Emergency Management Plan (CEMP), approved by the local emergency management agency to ensure the safety and welfare of all residents. The findings included: On the administrator provided a Comprehensive Emergency Management Plan (CEMP) that had been approved on , . The letter indicated the facility's CEMP was approved through . Review of the Administrator's employee file on indicated a hire date of . Although the administrator was hired on ; the CEMP was not revised and submitted until . During an interview on at 12:49 p.m., the Administrator confirmed the facility does not have an approved and current CEMP and indicated that the CEMP was submitted late on . Class III	CZ830		

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
	AL11967856	A. BUILDING: _____ B. WING _____	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO PALMS ASSISTED LIVING COMMUNI	5601 N HONORE AVE SARASOTA, FL 34243

(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