

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

700 JOHN RINGLING BLVD
SARASOTA, FL 34236

(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, and visitation form survey 3/21/24 at Plymouth Harbour, Inc., an assisted living facility in Sarasota, Florida. The following is a description of the deficiencies.	A 000		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for pain, not to exceed 4 tablets per day." The revised instructions,	A 056		

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 A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED /2024
---	---	---	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

700 JOHN RINGLING BLVD
SARASOTA, FL 34236

(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 056	Continued From page 1 including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxed, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not	A 056		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

700 JOHN RINGLING BLVD
SARASOTA, FL 34236

(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 056	Continued From page 2 dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the timely refill of medications for 1 (Resident #11) of 3 residents reviewed for refill of medications. The findings included: Review of the facility policy: Medication Ordering and Receipt, effective date May 2019: H. Refill requests should be made when a seven (7) day supply remains to allow for timely refill of the prescription. Review of the Medication Policy and Procedures: 1. Plymouth Harbor will assist in the ordering of medications including obtaining the physician order, sending the order to the pharmacy, communicating the need for refills, providing insurance information, and checking medications upon delivery. Review of the Active Order Summary Report for	A 056		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

PLYMOUTH HARBOR, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

700 JOHN RINGLING BLVD
SARASOTA, FL 34236

(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 056	Continued From page 3 Resident #11 revealed an active order for Tylenol Oral Tablet 325 milligrams (mg), give 325 mg by mouth every 4 hours as needed for pain every 4-6 hours as needed (, , /20/23. Review of the medical record for Resident #11 revealed a physician , , /19/23: "okay to take Tylenol 325 mg every (q) 4-6 hours as needed (prn) for pain." Review of the Resident Health Assessment for # 4/21/22 revealed the resident required assistance with medication administration. Review of the Medication Observation Record (MOR) for March 2024 revealed an entry for Tylenol 325 milligrams (mg) Give 325 mg by mouth every 4 hours as needed for pain every 4-6 (prn) , /23. On 3/21/24 at 11:23 a.m., during observation of the medications in the locked cabinet for Resident #11, Licensed Practical Nurse (LPN) Staff A said Tylenol 325 mg is not in the cabinet. She said someone must have forgotten , , , , , refill. On 3/21/24 at 12:17 p.m., during a telephone interview with the pharmacy customer service representative she said the pharm , , , , , physician's order dated 10/19/23 for Resident #11. She said they did not receive a prescription for the Tylenol 325 mg. The customer service representative said the order was never filled by the pharmacy because they , , , a prescription from the facility. On 3/21/24 at 12:25 p.m., during a telephone interview with the licensed pharmacist, she said	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED /2024
NAME OF PROVIDER OR SUPPLIER PLYMOUTH HARBOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 700 JOHN RINGLING BLVD SARASOTA, FL 34236		
(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 056	Continued From page 4 the physician order /23 that was submitted to them by the facility was not a valid physician's order because it did not include quantity or refill amount. She said the Tylenol 325 mg may appear on the facility MOR, but it was never filled and 3/21/24 at 12:49 p.m., the Administrator contacted the Director of Nursing (DON) by phone. The DON said in a telephone interview the expectation is the nurse requests a refill from the pharmacy before the medication runs out, for example when there are 2 pills remaining for the resident to take. She said the residents should of medication. On 3/21/24 at 2:30 p.m., the Acting Administrator unlocked the medication cabinet for Resident #11. She looked through all of the medications in the cabinet. She said there was no Tylenol 325 mg for Resident #11.	A 056		
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	A 078		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

700 JOHN RINGLING BLVD
SARASOTA, FL 34236

(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 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 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	A 078		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

700 JOHN RINGLING BLVD
SARASOTA, FL 34236

(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 6 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: Based on record review and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable disease and evidence of freedom from tuberculosis (TB) documented annually thereafter for 3 (Staff E, F, G,) of 5 employee records reviewed. The findings included: Staff E's employee file revealed a hire date of 12/26/23 as a care partner. Staff contained documentation of a Tuberculosis Symptoms Evaluation and Risk Assessment dated 12/18/23 m of Screening Pre-Employment Survey form, with a Tuberculin skin test complete on 12/18/23 and 1/6/24, with a statement indicating that staff E was free from signs and symptoms of communicable disease including Tuberculosis, the statement was signed by a registered nurse and not a healthcare provider. There was no documentation of a statement from a health care provider that indicated that Staff E was free from signs or symptoms of communicable disease including Tuberculosis.	A 078		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

**700 JOHN RINGLING BLVD
SARASOTA, FL 34236**

(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 7 Review of Staff F's employee file indicated a hire /3/24 as a Certified Nursing Assistant (CNA). Review of her Infection Control Screening Pre-Employment Survey was incomplete and did not contain the required health care provider signature stating that the employee is free of any communicable disease. Record review of Staff G's m, , revealed a hire date of 10/17/23 as a care partner. Staff G's file contained documentation of , mptoms Evaluation and Risk Assessment for dated 8/24/25 and documentation m, , Tuberculosis Consent record form, with a Tuberculin skin test completed , /23. Further review , m of a Tuberculin Skin testing given on 10/5/23 and read on 10/9/23. There was no documentation of a statement from a health care provider that indicated , was free from signs or symptoms of communicable disease including Tuberculosis. During an interview on 3/21/24 at 12:10 p.m., the Vice President of Health Services (VPHS) , med that there was no health care provider signature on the communicable disease statement for Staff F. On 3/21/24 at 12:45 p.m., the Vice President of Health Services reviewed the TB screening form and statement for Staff E and confirmed the statem by a Registered Nurse (RN) and does not meet regulation requirements as the statement was not signed by a healthcare provider. On 3/21/24 at 1:10 p.m., the Vice President of Health Services confirmed the documentation for	A 078		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

**700 JOHN RINGLING BLVD
SARASOTA, FL 34236**

(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 8 Staff G does not include a statement signed by the healthcare provider indicating she was free from signs and symptoms of communicable disease including TB. Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011(2-3) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee 's personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice	A 081		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

**700 JOHN RINGLING BLVD
SARASOTA, FL 34236**

(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 081	Continued From page 9 training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in infection control,	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED /2024
NAME OF PROVIDER OR SUPPLIER PLYMOUTH HARBOR, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 700 JOHN RINGLING BLVD SARASOTA, FL 34236		
(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 081	Continued From page 10 including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its infection control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident abuse, neglect, and exploitation. The facility must use its abuse prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training	A 081			

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

700 JOHN RINGLING BLVD
SARASOTA, FL 34236

(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 081	Continued From page 11 within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility employees complete the in-service training required by Florida Administrative Code within 30 days of employment for 1 (Staff ..., employee files reviewed. The findings included: Record review found Staff E was hired on 12/26/23 as a Care Partner. Further review of Staff E's file contained no evidence of completion of ADL ... 3 hours and no 1 hour training in Infection Control completed within 30 days of hire. On 1/29/24 at 1:10 p.m., the Vice President of Health Services confirmed the ADL Behavior and Needs training for staff E does not meet regulation requirements of 3 hours, and there was	A 081		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

**700 JOHN RINGLING BLVD
SARASOTA, FL 34236**

(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 081	Continued From page 12 no documentation of completion of 1 hour training for infection control for Staff E. Class III	A 081		
A 090 SS=D	59A-36.011(11) FAC Training - Do Not Resuscitate Orders (11) DO NOT RESUSCITATE ORDERS TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding Do Not Resuscitate Orders. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding DNROs within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility employees complete at least one hour of training in the facility's policies and procedures regarding Do Not Resuscitate Orders (DNRO) within 30 days after employment and maintain documentation of completion for 4 (Staff D, E, F and G) . . . employee files reviewed. The findings include: Record review for Staff D revealed a hire date of 10/23/23 as a care partner. Further review	A 090		

Agency for Health Care Administration

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

700 JOHN RINGLING BLVD
SARASOTA, FL 34236

(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 090	Continued From page 13 revealed no documentation of completion 1 hour of Do Not Resuscitate Order training. Record review for Staff E revealed a 12/26/23 as a care partner. Further review revealed no documentation of completion 1 hour of Do Not Resuscitate Order training. Record review for Staff F date of 1/3/24 as a care partner. Further review revealed no documentation of completion 1 hour of Do Not Resuscitate Order training. Record review for a hire date of 10/17/23 as a Certified Nursing Assistant. Further review revealed no documentation of completion Do Not Resuscitate Order training. On 3/21/24 at 1:38 p.m., the Vice President of Health Services confirmed no documentation of completion of 1 hour training for DNRO in the employee record for Staff D, E, F and G. Class III	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

**700 JOHN RINGLING BLVD
SARASOTA, FL 34236**

(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 SS=C	435.12(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		

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: AL11911610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER PLYMOUTH HARBOR, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 700 JOHN RINGLING BLVD SARASOTA, FL 34236	
(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)
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 4 (Staff D, E, F and G) of 5 employees reviewed, had the Level 2 background screening employment status updated within 10 days on the Agency for Healthcare Administration (AHCA) Background screening clearinghouse website pursuant to chapter 435. This had the potential for staff with disqualifying offenses to have access to adults. The findings included: Record review of Staff D's file revealed a hire date of as a Care Partner. Review of the Agency's clearing house employee roster revealed Staff D was added on the clearing house roster on , 102 days after hire. Record review of Staff E's file revealed a hire date of as a Care Partner. Review of the Agency's clearing house employee roster	CZ814	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/21/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLYMOUTH HARBOR, INC.

**700 JOHN RINGLING BLVD
SARASOTA, FL 34236**

(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 revealed Staff E was added on the clearing house roster on . . . , 38 days after hire. Record review of Staff F's file revealed a hire date of . . . as a Care Partner. Review of the Agency's clearing house employee roster revealed Staff F was added on the clearing house roster on . . . , 30 days after hire. Record review of Staff G's file revealed a hire date of . . . as a Care Partner. Review of the Agency's clearing house employee roster revealed Staff G was added on the clearing house roster on . . . , 108 days after hire. On . . . at 12:20 p.m., the Vice President of Health Services confirmed the staff were not added to the facility background screening clearing house roster within the required time frames. Unclassified	CZ814		