

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 emergency power plan monitoring and complaint survey #2023008997, 2024004684, 2024010031, 2024003463, 2024003526 was conducted on _____ through ____//24, at Harborchase at Sarasota, an assisted living facility in Sarasota, Florida. Complaint # 2023008997 was substantiated without deficiencies. Complaint #2024004684 had three allegations; two were not substantiated; two were substantiated at A 0030, A 0093, and A 0052. Complaint # 2024010031 had two allegations; one allegation was not substantiated; one allegation was substantiated at A 0030. Complaint # 2024003463 was not substantiated Complaint # 2024003526 was not substantiated. The following is a description of the deficiencies. .	A 000			
A 030 SS=D	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	A 030			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL. 34233		
(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 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; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96-_____ or 1(800)962-2873. The telephone numbers must be posted in close 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 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 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2024
---	--	---	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF SARASOTA

**5311 PROCTOR RD
SARASOTA, FL. 34233**

(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 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. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or arrangement of transportation to health care . . . , and the performance of health	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 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 ill, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without harassment, 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, responsibilities, and prohibitions set forth in this part is posted in a	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL. 34233		
(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 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 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 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 interviews, the facility failed to ensure staff were able to communicate with residents in a manner they could understand for 2 (Resident #5 and #9) of 2 residents reviewed. This had the potential to impact all residents residing in the memory care unit. The findings included: On at 8:50 a.m., Resident #9 was observed in bed. Staff B, Care partner (CP) brought Resident #9's breakfast to his room. She required the use of Google translate to answer questions about what the resident was eating for breakfast. On at 11:15 a.m., during an interview, a third-party provider said she sees residents at the facility several days every week. She said "staff communication is hindering care here. It is very frustrating, the lack of follow through is really a problem." Communication problems exist here, care partners are not being able to communicate and understand what a resident says or needs. On at 12:08 p.m., during a telephone interview Resident #5's were missing. The communication has been challenging, with caregivers speaking Spanish, and getting issues	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 resolved with management. On at 1:27 p.m., during an interview, the Memory Care Director said," Google translate is what the staff uses for communicating with each other, a lot of them don't speak a word of English. I have asked for them to be replaced with staff who speak English. It is terribly confusing for the residents. It's a mess of issues. There are a lot of Spanish speaking staff, and it's not working, and its really frustrating."	A 030			
A 052 SS=D	On at 2:40 p.m., the Executive Director said, I have had concerns brought to me about staff speaking and understanding very little English. Class III . 429.256(); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 052	Continued From page 8 from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or .	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL. 34233		
(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 052	Continued From page 9 preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 052	Continued From page 10 self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/12/2024	
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 052	Continued From page 11 assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff who assist residents with self-administration of medications, do so in accordance with proper procedure for 7 (Residents #6, # 9, #10, #11, #13, #14) of 15 residents reviewed during medication observation. The findings included: Review of facility policy; Standard 8.06: Resident medication assistance- issued , revised , reviewed .. Protocol: Medications may be assisted for residents who are unable to self-administer their medications by a trained associate or licensed nurse in accordance with state regulations and with an order from their physician. . . . The qualified medication assistance associate will go to the community's designated area with the hall book containing the medication Observation Record or MAR book. . . .The associate will wash their (or use sanitizer).... Assistance with self-administration of medication includes: Taking the medication in its previously properly labeled container...from where it is stored to the resident. . . .In the presence of the resident, reading the label, opening the containing, removing a prescribed about of medication from the container and closing the container. . . . Placing an oral dosage in the resident's or placing the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/12/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF SARASOTA

**5311 PROCTOR RD
SARASOTA, FL 34233**

(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 052	Continued From page 12 dosage in another container and helping the resident by lifting the container to his or her ... Record review for Resident #14 revealed a Health Assessment Form 1823, and dated by the healthcare provider, indicating Resident #14 required assistance with self-administration of medications. On at 11:39 a.m., Medication Technician (MT) Staff A was observed assisting Resident #14 with medications. Staff A unlocked the medication cart, removed medication packages from the cart, opened the package and place in a plastic wrapper, crushed the medication, mixed it in chocolate pudding and spooned the medication into the resident's . Resident #14 was not able to assist with putting the medication into her Record Review for Resident #11 revealed a Health Assessment Form 1823, and dated , by the healthcare provider, indicating Resident #11 required assistance with self-administration. On at 12:30 p.m., MT Staff A was observed assisting Resident #11 with medications. Staff A unlocked the medication cart, removed the medication package containing 2 tablets and one Orolate capsule. The was crushed, and the capsule was opened and combined with the and mixed in pudding. MT Staff A attempted to have Resident #11 hold the spoon to assist when Resident #11 became agitated and spit out part of the pudding containing the medication. It is unclear how much of the medication was taken.	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 052	Continued From page 13 On at 12:32 p.m., MT Staff A said she usually just spoons the medication into Resident #11's because he is unable to assist with self-administration of medication. Record review for Resident #13 revealed at Health Assessment Form 1823 signed and dated , by the healthcare provider, indicating Resident #13 required assistance with self-administration. On at 12:35 p.m., MT Staff A was observed assisting Resident #13 with medications. MT Staff A removed the medication package containing Carb/Levo tab 25-100 mg. MT Staff A was observed to crush the medication and spoon feed to Resident #13. The resident was unable to hold the spoon or cup to assist with self-administration of medication during the medication observation. Record review for Resident #10 revealed at Health Assessment Form 1823 signed and dated , by the healthcare provider, indicated Resident #10 required assistance with self-administration. On at 1:45 p.m., MT Staff A was observed assisting Resident #10 with medications. MT Staff A removed the medication packages containing one tablet of 25 mg, 2 tablets of 325 mg and 1 tablet of .5 mg. MT Staff A was observed to crush the medications and mixed in pudding. MT Staff A was observed to spoon feed the medication to Resident #10. The resident was unable to hold the spoon or cup to assist with self-administration of medication during the medication observation.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233			
(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 052	Continued From page 14 Record review for Resident #6 revealed a Health Assessment Form 1823 signed by the healthcare provider on _____, indicating Resident #6 required medication administration. On _____ at 1:55 p.m., MT Staff A was observed assisting Resident #6 with medications. MT Staff A removed the medication packages containing one tablet of _____, 25 mg, and 1 tablet of _____, .5 mg. MT Staff A was observed to crush the medications and mix the medications together in applesauce. MT Staff A was observed to spoon feed the medication to Resident #6. Staff A is not licensed to administer medications. Record review for Resident #9 revealed a Health Assessment Form 1823 signed, and dated on _____ by the healthcare provider, indicated Resident #9 required assistance with self-administration of medication. On _____ at 2:00 p.m., MT Staff A was observed assisting Resident #9 with medications. MT Staff A removed the medication packages containing 1 capsule of _____, and a prefilled syringe containing .25 ml of _____. MT Staff A was observed to open the capsule and mix the granules in pudding. MT Staff A spoon feed the medication to Resident #9. MT Staff A proceeded to insert the _____ filled syringe into the residents' cheek and push the plunger. The resident was unable to hold the spoon or cup to assist with self-administration of medication during the medication observation. Record review for Resident #7 revealed a Health Assessment Form 1823 signed, and dated on _____ by the healthcare provider, indicated Resident #7 required assistance with self-administration of medication.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 052	Continued From page 15 On at 3:56 p.m., MT Staff B was observed assisting Resident #7 with medications. MT Staff B removed the medication packages containing 125 mg. 180 mg and .5 mg. MT Staff B did not sanitize his prior to medication assistance and did not inform Resident #7 of the medications he was taking. On at 4:36 p.m., upon completion of the medication pass MT Staff B said he has not had control training and forgot to sanitize his between assisting residents with their medications. He verified he will give Resident #9 from the prefilled syringe at 10:00 p.m. and squirt the in his cheek. MT staff B verified Resident #9 is not able to assist to take his medications. On at 4:51 p.m., the Director of Resident Care (DRC) said washing or use of sanitizer should be done before and after any resident care or medication assistance. She said staff have been instructed to read the medications names off the label to the resident. at 9:40 a.m., Staff H, Licensed Practical Nurse (LPN) said she and the DRC were responsible for control in services but there has not been one. She verified if a resident needed , it would be given by a nurse. She verified there is no nurse around the clock and said she was not aware Resident #9 was taking . She verified Resident #9 was not able to push the plunger for his own . The MT's cannot give the because at that point in time it is administration. If residents are being spoon fed medications and not holding the spoon it is administration and not	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 052	Continued From page 16 assistance. Class III .	A 052			
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 , , not to exceed 4 tablets per day." The revised instructions, 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	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 17 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 dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 18 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, record review, and interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medication were refilled in a timely manner for 1 (Resident #7) of 7 residents observed being assisted with self-administration of medications. The findings included: Review of the facility policy titled: Standard 7.13; Resident Medication Supervision- Issued reviewed Medication Supervision Procedure: Problem Solving: "If a medication is missing, fill out an incident report, notify the Director of Resident Care, or nurse if applicable, ED or manager on duty. When medications are unavailable, the community should make every effort to obtain the medication for the resident before the scheduled dose. Record review for Resident #7 revealed a Health Assessment Form 1823 signed, and dated on _____ by the healthcare provider, which	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/12/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF SARASOTA

**5311 PROCTOR RD
SARASOTA, FL 34233**

(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 19 indicated Resident #7 required assistance with self-administration of medication. Resident #7's diagnoses included _____ due to _____'s and _____. Review of the physician orders noted _____ / _____ tab 300-30mg with the instruction to take 1 tablet three times daily, morning, noon and bedtime. On _____ at 11:30 a.m., MT Staff A was observed assisting Resident #7 with medications. MT Staff A charted on the electronic medication administration record the _____ / _____ was not available. On _____ at 11:35 a.m., following the medication observation, MT Staff A said the medication has been on order. MT Staff A said, pharmacy is notified by the computer and the nurse sees the manifest and alerts on the computer. MT Staff A did not notify the physician or nurse of the medication not being available. MT Staff A confirmed the last dose available was on _____ at breakfast. Observation of the electronic medication administration record revealed the medication has not been available since _____ at noon. The medication is ordered to be given three times daily. On _____ at 1:10 p.m., during an interview, the Director of Nursing said when medications are low, the MT will let the nurse know and the order is sent to the pharmacy, and the nurse will follow up. The pharmacy will contact the facility and the physician if a new prescription is needed to avoid running out.	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 20 On at 1:20 p.m., MT Staff A said she orders medications days prior to running out. She said she pulled the sticker off the card and faxed the refill request to the pharmacy for Resident #7's medication. On at 2:09 p.m., Staff H, Licensed Practical Nurse (LPN) said the pharmacy will continue to send out / if there are refills on the prescription. The pharmacy will also send a manifest that indicates needing a clarification or a new order. The MT's usually communicate to me and tell me when they are running low on any residents medications. Staff H verified Resident #7 has been out of the / for 20 scheduled doses over 7 days. Staff H said we should have notified the physician that the medication was not available. Staff H confirmed she did not have any manifests or documentation indicating the medication had been re-ordered to prevent resident #7 from running out of the medication. Class III .	A 056			
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.frules.org/Gateway/reference.asp?No=Ref-04003 , and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL. 34233		
(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 093	Continued From page 21 National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 093	Continued From page 22 diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 093	Continued From page 23 resident, must be on (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure therapeutic diets ordered by the physician were followed as prescribed, for 1 (Resident #9) of 2 residents reviewed for therapeutic diets. The findings included: Record review for Resident #9 revealed a Health Assessment Form 1823 signed, and dated on by the healthcare provider, indicated Resident #9 required strict 1:1 feeding [assistance], level 4 pureed diet with nectar thickened liquids. A dietary communication form reviewed, documented the diet order and indicated the order was sent to the kitchen on On at 8:30 a.m., Resident #9 was observed lying in bed. Staff B care partner entered the room with breakfast and began to feed Resident #9. Resident was observed being fed a pureed diet by Staff B, Care Partner (CP).	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR RD SARASOTA, FL 34233		
(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 093	Continued From page 24 There were no thickened liquids on the tray or bedside table. Resident #9 drank the juice served with breakfast and a glass of water on the bedside table and was observed coughing. On at 2:00 p.m., MT Staff A was observed to give Resident #9 water during a medication pass that was not thickened. On at 3:50 p.m., Staff D, CP, said Resident #9 does not have any dietary restrictions but is on a pureed diet. She said she gives the resident water and juice and did not know they needed to be thickened. On at 4:51 p.m., during an interview, the Director of Nursing (DON) said she was not aware Resident #9 had a physician order for thickened liquids. The DON said it was not noted on the kitchen dietary correspondence posted on the kitchen wall. The DON verified Resident #9's Health Assessment Form 1823 and dietary communication form both indicated the resident was to be given thickened liquids. The DON confirmed the water and cranberry juice provided on the dinner tray were not thickened. On at 9:14 a.m., during an interview, the DON said the kitchen manager would update the resident diets in the memory care kitchen. The DON said she educated staff and the memory care director last evening and updated the kitchen wall chart indicating resident #9 required thickened liquids. The DON said she did not document the staff inservice completed. On at 9:40 a.m., Staff H, Licensed Practical Nurse (LPN) said during an interview she saw the order for thickened liquids and sent the order to the kitchen on . LPN Staff H	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/12/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF SARASOTA

**5311 PROCTOR RD
SARASOTA, FL 34233**

(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 093	Continued From page 25 said she makes rounds but was not aware the resident was not being given thickened liquids. She said Resident #9 is an risk and this would increase the risk of developing . On at 11:06 a.m., Staff H, LPN verified resident had freshly supplied apple juice at the bedside. On at 1:27 p.m., during an interview, the MCD said she was told this morning that Resident #9 needed thickened liquids. The MCD said she communicated to her staff Resident #9 needed thickened liquids and did not know why he was still being given thin liquids. **Photographic evidence obtained** Class III	A 093		