Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970223	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
81 OAKS SENIOR LIVING	8000 HAWKINS RD SARASOTA, FL 34241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey for complaints #2024012031, #2024012155, and #2024012955 was conducted on through at 81 Oaks Senior Living, an assisted living facility in Sarasota, Florida. Complaint #2024012031 was not substantiated. Complaint #2024012155 was substantiated without citation. Complaint #2024012955 was substantiated with citation at A165. The following is a description of the deficiency.	A 000		
A 165 SS=E	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints;	A 165		

AHCA Form 3020-0001

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

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A 165	Continued From page 1 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional	A 165		

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A 165	Continued From page 2 who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on review of facility policy and documents and administrator interview, the facility failed to manage the facility's internal risk management and quality assurance program by failing to investigate reported and document possible causes for the to reduce their frequency. A total of 12 facility Incident Report Forms were reviewed for and elopement. Of the 12 reports, the 10 reports related to lacked investigation as to possible causes of the incidents.	A 165		

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A 165	Continued From page 3 The findings included: On , review of the facility's policy DP04, Incident Reports, policy date: revealed the Procedure included: 3. The Community will investigate all internal occurrence reports and state required incident reports. a. Investigations shall include but not be limited to: i. A review of the factors leading up to the incident. ii Nature of the incident. iii. Disposition of the incident. . Steps to prevent similar incidents from occurring. 1. Staff training on any prevention mechanisms to be set in place by the Community. On review of the facility's Incident Reporting Form for an unwitnessed incident for Resident #5 on revealed a description of the incident and action taken by staff. The Administrator Report section was blank and there was no investigation as to possible steps to prevent similar incidents from occurring. In an interview on at 11:27 a.m., Resident #5's family member said on she offered the Memory Care Director a video of Resident #5's , but the Director declined to view the video. On review of the facility's Incident Reporting Forms for involving Resident #6 revealed unwitnessed on , , and . Each report included a description of the incident and action taken by staff. The Administrator Report section was blank	A 165		

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A 165	Continued From page 4 and there was no investigation as to possible steps to prevent similar incidents from occurring. On review of the facility's Incident Reporting Forms for involving Resident #7 revealed unwitnessed on , , , and witnessed on and . Each report included a description of the incident and action taken by staff. The Administrator Report section was blank and there was no investigation as to possible steps to prevent similar incidents from occurring. During an interview on at 11:30 a.m., the president acknowledged she did not address each on the incident report and acknowledged the Health and Wellness Director is not included in completing the incident reports. During an interview on at about 1:00 p.m., the Administrator said she only reviewed the Incident Reports for signatures and dates.	A 165		