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
	AL11911906	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DEER CREEK SARASOTA	8450 MCINTOSH ROAD SARASOTA, FL 34238

(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, Limited Nursing Services, Emergency Power Plan Monitoring, Health Facility Reporting System, visitation form and complaint survey for #2024013962 was conducted on through at Brookdale Deer Creek, an assisted living facility in Sarasota, Florida. Complaint #2024013962 was substantiated at A0032, A0010. The following is a description of the deficiencies. .	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing	A 010		

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A 010	Continued From page 1	A 010		

that service or treatment are met by the facility or a third party.
(b) A facility may admit or retain a resident who requires the use of assistive devices.
(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.
(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:
a. Move, turn, or reposition without total physical assistance;
b. Transfer to a chair or wheelchair without total physical assistance; or
c. Sit safely in a chair or wheelchair without personal assistance or a physical .
2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.
3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and

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A 010	Continued From page 2 agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a pressure	A 010		

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A 010	Continued From page 3 may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.	A 010		

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A 010	Continued From page 4 (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to update each resident's Health Assessment Form 1823 after any significant change for 3 (#3, #5, #11) of 3 residents reviewed. The findings included: Requested and obtained a list of residents deemed as an elopement risk. On at 2:00 p.m.. said, "All 32 residents in the facility were deemed as an elopement risk, and a corresponding list was provided. 1. Record review showed Resident #3 was admitted to the facility on . The resident list provided by the facility to the surveyors during the survey indicated Resident #3 was identified as an elopement risk. The Health Assessment (HA) Form 1823 reviewed for Resident #3 completed on , indicated that Resident #3 was not an elopement risk. The service plan for Resident #3 dated did not address Resident #3's elopement risk. There was no evidence of an updated HA Form 1823 on record reflecting Resident #3's elopement risk.	A 010		

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A 010	Continued From page 5 2. Record review showed Resident #5 was admitted to the facility on . The resident list provided by the facility to the surveyors during the survey indicated Resident #5 was identified as an elopement risk. The Health Assessment Form reviewed for Resident #5 completed on , indicated that Resident #5 was not an elopement risk. Resident #5 eloped from the facility on . There was no updated Health Assessment Form 1823 on record for Resident #5 after the elopement on . The Service plan for Resident #5 dated did not address Resident #5's elopement risk. There was no updated service plan after Resident #5's elopement on . 3. Record review showed Resident #11 was admitted to the facility on , and was included on the list provided of residents deemed as elopement risk. The Health Assessment Form reviewed for Resident #11 dated , indicated Resident #11 was not deemed as an elopement risk. The Service plan for Resident #11 developed on , did not indicate Resident #11 was an elopement risk. There was no evidence of updated HA Form 1823 on record reflecting Resident #11's elopement risk. During an interview on at 1:00 p.m., the Clinical Services , (CSS) confirmed that Resident #3, #5, and #11's Health Assessment Forms 1823 were not updated as required. The CSS also confirmed the service plans for Resident #3, #5, #11 were not updated. The CSS stated all service plans needed to be updated after a significant change. During an interview on at 2:30 p.m., the	A 010		

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A 010	Continued From page 6 Administrator confirmed Resident #3, #5, and #11's Health Assessment Forms 1823 were not updated as required. The Administrator also confirmed the service plans for Residents #3, #5, and #11 were not updated in order to include residents elopement risk. Class III .	A 010		
A 032 SS=E	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of	A 032		

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A 032	Continued From page 7 all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to conduct elopement drills according to Section 429.41(1)(k), F.S. by failing to ensure all administrators and direct care staff participated in	A 032		

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two elopement drills annually, which must include a review of the facility's procedures to address resident elopement. Failure to conduct elopement drills as required contributed to Resident #5's elopement on . The facility failed to ensure that residents deemed as an elopement risk had identification on their person that included their name, the facility's name, address, and telephone number. The facility failed to ensure the elopement policy and procedure included language indicating that all staff shall participate at a minimum of two resident elopement drills each year pursuant to Section 429.41(1)(k), F.S.

The findings included:

Elopement Risk policy. Effective . Last revised on . Policy Overview: Residents who are at risk of elopement should be evaluated by a healthcare provider or mental healthcare provider within 30 calendar days of being admitted/moved into a community. The elopement risk is documented on the Florida 1823 Health Assessment Form. . . .Policy Details: 2. a) Residents assessed as risk for elopement or with any history of elopement should have identification on their persons that includes their name and the community's name, address, and telephone number. . . 4. The risk of elopement will be identified in the resident's service plan. . . 5. Missing resident drills should be conducted quarterly for all shifts.

Missing Resident Drills Policy. Effective . Last revised 8/20023 . . Policy Details: 1. The Executive Director ("ED") is responsible for conducting or delegating the completion of monthly community missing resident drills.

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A 032	Continued From page 9 On at 10:10 a.m., during an interview, the Clinical Services , (CSS) said that the facilities complete monthly elopement drills and not quarterly. The CSS said there was no additional policies. CSS was not able to provide a Policy indicating that all administrators and direct care staff shall participate at a minimum of two resident elopement drills each year pursuant to Section 429.41(1)(k), F.S. 1. Record review showed Resident #5 was admitted to the facility on , the resident list provided indicated Resident #5 was identified as an elopement risk. The Health Assessment Form for Resident #5 completed on , indicated Resident #5 was not an elopement risk. Resident #5 eloped from the facility on . There was no updated Health Assessment Form on record for Resident #5 after the elopement of . The Service plan for Resident #5 dated did not address resident #5's elopement risk status. There was no updated service plan after Resident #5's elopement. Further review found no evidence of preventative interventions for elopement in place for Resident #5. On at 1:00 p.m., during an interview, the Administrator said the facility does not have any cameras, and she interviewed all of the staff present and could not conclude as to how Resident #5 exited from the locked front door. The Administrator said she assumed Resident #5 followed a visitor leaving and since there is a 15 second gap before the alarm goes off, she was able to leave the unit. An observation on at 11:32 a.m., found Resident #5 did not have identification on her person that included her name, the facility's	A 032		

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name, address, and telephone number. Staff A present at time of the observation confirmed Resident #5 did not have identification on her person that included her name, the facility's name, address, and telephone number.

During an observation with Administrator on at 11:35 a.m., the Administrator confirmed Resident #5 did not have identification on her person that included her name, the facility's name, address, and telephone number. During the observation, the Administrator said that all residents in the facility were elopement risk and should have have identification on their person that included their name, the facility's name, address, and telephone number. The Administrator said the nursing staff are supposed to check their identification during medication assistance.

Observation on at 11:42 a.m. with Agency Nurse Staff A, found only Residents #1, #10, #12, #13, and #14 out of 32 residents identified as an elopement risk had identification on their person that included their name, the facility's name, address, and telephone number. Staff A confirmed the observation.

On at 11:50 a.m., during an interview, Care Partner Staff B said she was the one who found Resident #5 outside close to the front door. Staff B could not provide any explanation as to how Resident #5 left the secured unit. Staff B acknowledged only Residents #1, #10, #12, #13, and #14 of 32 residents in total had identification on their person that included their name, the facility's name, address, and telephone number.

On at 2:00 p.m., during an interview, the Clinical Services , (CSS) said all 32

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A 032	Continued From page 11 residents in the facility were an elopement risk and confirmed they should have identification on their person that included their name, the facility's name, address, and telephone number. The CSS said the nursing staff are supposed to check on residents identification at least once a day during assistance with medications. Documentation of employee list indicated there is a total of 23 employees working for the facility of which 17 are the Administrator and direct care staff. Record reviewed of elopement drills completed documented the following: On only 3 staff participated. On only 4 staff participated. On only 2 staff participated. On only 4 staff participated. On only 2 staff participated. On only 4 staff participated. On only 6 staff participated. On only 2 staff participated. On only 4 staff participated. On only 3 staff participated. On only 2 staff participated. The following administrative or direct care staff did not participate in 2 drills during 2024: The Executive Director hired on , and Direct Care Staff K hired on , and Direct Care Staff D hired on lacked documentation of any participation in elopement drills in 2024. Direct Care Staff E hired on attended 1 drill on , Direct Care Staff F hired on attended 1 drill on , and Direct Care Staff J hired on attended 1 drill on and lacked documentation of a second elopement drill in 2024.	A 032		

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A 032	Continued From page 12 Further review of facility records revealed an in-service training on elopement that was completed on as a result of the elopement that took place on with 11 of 23 staff participated. On at 2:25 p.m., during an interview the maintenance director said he was the one responsible for the completion of monthly elopement drills and he did not have a master employee list in order to make sure administrators and direct care staff participated in 2 yearly elopement drills as required. He said no one ever told him he needed to do that and he used whatever staff was present at the time. On at 2:50 p.m., During an interview the Administrator said all the department heads have a current staff list and the Maintenance Director was supposed to use that master list in order to make sure that required staff participated on elopement drills twice a year as required. The Administrator confirmed that only 4 staff participated in an elopement drill after the elopement that took place on , and only 11 out of 23 staff participated in the in- service for elopement that took place on as a result of the elopement. Class III .	A 032		
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	A 078		

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A 078	Continued From page 13 individual does not have any signs or symptoms of communicable . 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 examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , 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 (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.	A 078		

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A 078	Continued From page 14 (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff 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 for 1 (Executive Director) of 3 staff reviewed, provide evidence of a negative examination on an annual basis. The findings included: Record review of the Executive Director's employee file on showed a negative ( ) examination on . There was no further documentation of an updated annual rescreening for in her file therafter. During an interview on at 10:28 a.m., the Executive Director acknowledged that her annual screen was late. Class III	A 078		

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A 078	Continued From page 15	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) 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 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	A 081		

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A 081	Continued From page 16 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 control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of	A 081		

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A 081	Continued From page 17 29 CFR 1910.1030, relating to borne , , 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 , neglect, and , . The facility must use its 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 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.	A 081		

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A 081	Continued From page 18 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 1 (Staff C) of 3 staff reviewed, complete 1 hour of Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting training within 30 days of hire as required. The findings included: Review of Licensed Practical Nurse (LPN) Staff C's employee file showed a hire date of . It contained documentation of Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting training completed on and was not within the required timeframe for completion. During an interview on at 9:46 a.m., the Executive Director confirmed that the documentation of the required training within Staff C's employee file was not completed timely. Class III .	A 081		

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A 082	Continued From page 19	A 082		
A 082 SS=D	59A-36.011(4) FAC Training - /	A 082		

(4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 1 (Staff C) of 3 staff reviewed completed the required and (and) education course within 30 days of employment as required.

The findings included:

Review of Staff C's employee file showed a hire date of . Further review revealed documentation of completion of / training on and was not completed within the required timeframe.

During an interview on at 9:46 a.m., the Executive Director confirmed that Staff C's / training was not completed within the required timeframe.

Class III

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A 090	Continued From page 20	A 090		
A 090 SS=D	59A-36.011(11) FAC Training - (11) 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 . (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 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 that 1 (Staff C) of 3 staff reviewed, completed the required 1-hour in-service training on ( ) within 30 days after employment as required. The findings included: Review of Staff C's employee record showed a hire date of , as an Licensed Practical Nurse (LPN). Further review revealed documentation of completion of training on and was not completed within the required timeframe. During an interview on at 9:46 a.m., the Executive Director confirmed that Staff C did not have the required documentation of .	A 090		

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A 090	Continued From page 21 training within 30 days of hire in. Class III .	A 090		
A 093 SS=F	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.flrules.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 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	A 093		

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A 093	Continued From page 22	A 093		

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 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

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A 093	Continued From page 23 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 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, and interview, the facility failed to conspicuously post a current menu or make one easily accessible to residents. The findings included: On at 12:05 p.m., an empty board labeled	A 093		

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A 093	Continued From page 24 "breakfast", "lunch", and "dinner" was observed on the wall in dining # , and an empty case with "featured selections" was observed on the wall in the 2nd dining room. On at 9:30 a.m., an empty board labeled "breakfast", "lunch", and "dinner" was observed on the wall in dining # , and an empty case with "featured selections" was observed on the wall in the 2nd dining room. During an interview on at 9:46 a.m., the Executive Director said that the Dining Services Coordinator is responsible for posting the menus. She acknowledged that there were no menus posted in the dining rooms. Class III .	A 093		

Agency for Health Care Administration

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CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ˘ , to the Federal Bureau of Investigation for a national criminal history record check unless the person's ˘ , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ˘ , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ˘ , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ˘ , to the Federal Bureau of Investigation for a national criminal history record check. The ˘ , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ˘ , . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	CZ816		

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CZ816	Continued From page 1 professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No =Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service	CZ816		

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CZ816	Continued From page 2 s/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure and maintain documentation of a completed Affidavit of Compliance Attestation Form for 1 (Staff C) of 3 staff reviewed..	CZ816		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911906	A. BUILDING: _____ B. WING _____	02/13/2025

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CZ816	Continued From page 3 The findings included: Record review of Staff C's employee file revealed a hire date of as a Licensed Practical nurse (LPN). Further review showed an unsigned and undated Affidavit of Compliance Attestation Form. During an interview on at 9:46 a.m., the Executive Director acknowledged that the Attestation Form was not dated or signed. Class III .	CZ816		
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after	CZ830		

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CZ830	Continued From page 4	CZ830		

approval of its plan by the local emergency management agency, county health department, or Department of Health.
(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.
(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the state of emergency.
2. Is currently licensed.
3. Does not have a provisional license.
4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.
(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency

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CZ830	Continued From page 5	CZ830		

approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.

(4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.

This Statute or Rule is not met as evidenced by:
Based on record review, and interview, the facility failed to submit annually and maintain documentation of a current Comprehensive Emergency Management Plan (CEMP), approved by the local emergency management agency to ensure the safety and welfare of all residents.

The findings included:

On the Executive Director provided a Comprehensive Emergency Management Plan (CEMP), with an approval letter indicating the plan had been approved on . The letter further indicated the facility's CEMP was approved through .

Review of email correspondence showed that the

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CZ830	Continued From page 6 most recent CEMP was uploaded to Sarasota County Emergency Management on . During an interview on at 9:46 a.m., the Executive Director confirmed the facility still does not have an approved and current CEMP. Class III .	CZ830		