

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER SAVANNAH GRAND OF SARASOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 7130 BENEVA 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)	
A 000	Initial Comments An unannounced relicensure, emergency power plan, health facility reporting system, visitation form, and complaint survey for #2025001057 and #2025005479 was conducted on _____ through _____ at Savannah Grand of Sarasota, an assisted living facility in Sarasota, Florida. Complaint # 2025001057 was substantiated at A032. Complaint # 2025005479 was not substantiated The following is the 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	A 010		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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A 010	Continued From page 1 receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing 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.	A 010			

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A 010	Continued From page 2 (2) A resident may not be moved from one facility to another without consultation with and 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	A 010		

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A 010	Continued From page 3 receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of _____ 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	A 010			

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A 010	Continued From page 4 this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (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 interview, the facility failed to ensure resident Health Assessment Form 1823 was updated after a significant change in condition for 1 (Resident #2) of 3 residents reviewed. The findings included: On _____, during a review of the facility's records, it showed Resident #2 eloped from the facility on _____ at 7:00 p.m. On _____, during a review of Resident #2's record, it showed the resident's most recent 1823 dated _____ does not identify the resident as an elopement risk. On _____ at 10:45 a.m. during an interview the Director of Operations and Sales, said we put residents on the elopement list that we feel have behaviors that could lead to Elopement. It is not based on their 1823. The 1823 should have been updated after she eloped. On _____ at 10:51 a.m. during an interview, the Resident Care Coordinator, said Resident #2	A 010		

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A 010	Continued From page 5 is on the elopement list because if she gets sick, she might off again. Class III .	A 010			
A 032 SS=D	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 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	A 032			

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A 032	Continued From page 6 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, observation, and interviews, the facility failed to make, at a minimum, a daily effort to determine that residents at risk for elopement have identification on their persons that includes their name, the facility's name, address, and telephone number for 3 (Resident #1, #2, and #13) of 3 residents reviewed.	A 032			

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A 032	Continued From page 7 The findings included; Review of Facility elopement binder list residents #1, #2, and #13 as an elopement risk. On at 9:50 a.m., Resident #2 was observed sitting in a chair in the Dining room with a red walker beside her. Resident #2 did not have any identification bracelet or other identification on her person. On at 10:18 a.m., during observation, Resident #1 was sitting in her wheelchair in the Dining room. Resident #1 did not have any identification on her person. On at 2:00 p.m., Resident #13 was sitting in her room in a chair. Resident #13 not have any identification on her person. On at 3:22 p.m., during an interview the Resident care Coordinator said, just the residents that are an elopement risk wear identification bracelets. Resident #1 is supposed to have an identification bracelet on her wheelchair, Resident #13 has one on her ankle, but she always takes it off. Resident #2 has an identification bracelet on her walker, but she takes it off. On a review of the facility's policy and procedure titled: Strategies to Manage Elopement. Identified at Risk and/or Elopement Residents does not include the need for the residents determined to be at risk to have identification on their persons that includes their name, the facility's name, address and telephone number per FAC 59A-36.007(7).	A 032			

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SAVANNAH GRAND OF SARASOTA

**7130 BENEVA ROAD
SARASOTA, FL 34238**

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A 032	Continued From page 8 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 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.	A 078		

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A 078	Continued From page 9 Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility 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 that within 30 days of employment, staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable for 1(Staff E) of 3 records reviewed.	A 078		

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A 078	Continued From page 10 The findings included: On _____, review of employee record revealed that Staff E had a hire date of _____. Staff E's employee file contained no documentation of statement from healthcare providers indicating Staff E was free from signs/symptoms of communicable _____. On _____ at 8:30 a.m., during an interview, the Executive Director (ED) acknowledged the lack of documentation of statement by healthcare provider for free from signs/symptoms of communicable _____ for Staff E. Class III .	A 078		
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	A 090		

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A 090	Continued From page 11 failed to ensure all direct care employees completed 1 hour of () training based on the facility policies and procedures for 3 (Executive Director, Staff D, Staff E) of 3 records reviewed. The findings included: On review of employee record revealed the Executive Director (ED) had a hire date of . The Executive Director's employee file contained no documentation of having completed 1-hour training in based on the facility policies and procedures. On review of employee record revealed that Staff D had a hire date of . Staff D's employee file contained no documentation of having completed 1-hour training in based on the facility policies and procedures. . On review of employee record revealed that Staff E had a hire date of . Staff E's employee file contained no documentation of having completed 1-hour training in based on the facility policies and procedures. . On at 8:30 a.m., during an interview, the ED said that she was going to have a staff wide training for as she thinks all of the employees need to have the trainings. It was not part of their onboarding program. The ED stated "It didn't pay to try to get the trainings done while you were here." The ED acknowledged that the training was not documented .	A 090			

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A 090	Continued From page 12 Class III	A 090			
A 093 SS=E	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.frlrules.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 supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet	A 093			

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A 093	Continued From page 13 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 of such refusal. (f) For facilities serving three or more meals a	A 093		

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A 093	Continued From page 14 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 hand. (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 hand 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 menu review, observation, and interview, the facility failed to follow the printed menu, with substitutions noted before or when the meal is served, for 100% of its residents. The findings included: Menu review of lunch on _____ shows that Pork & Vegetable Stir Fry, Steamed Rice, Homemade	A 093		

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A 093	Continued From page 15 Pineapple Crisp, and a beverage was on the written menu posted outside of the dining room in the main hallway. ** Photographic evidence obtained ** On at 10:05 a.m., during an interview, Resident #8 stated that "the menu is never what is posted". On at 10:15 a.m., during an interview, Resident #9 said that the menu is always posted, but not always right. On at 12:00 p.m., during lunch service, Chicken Caesar Salad, Pie, and a beverage was observed on a written menu posted inside the dining room. ** Photographic evidence obtained ** On at 12:00 p.m., during observation of lunch service, all residents were served a Chicken Tender Salad with Russian , toasted bread, and a beverage. ** Photographic evidence obtained ** On at 8:00a.m., during breakfast service, Assorted Juice, Hot or Cereal, Pancakes, Bacon, Syrup, and a beverage, was observed on a written menu posted inside the dining room. ** Photographic evidence obtained **	A 093		

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A 093	Continued From page 16 On _____ at 8:10 a.m., during observation of breakfast service, all residents were served Juice, Pancakes, Sausage, Syrup, and a beverage. On _____, at 10:20 a.m., during an interview, the Executive Director (ED) said that she posts a monthly menu in the hallway and then posts an updated menu in the dining room for the current and upcoming day. The ED acknowledged that the menus do not match. The ED acknowledged that that what was served on _____ for lunch was not on either of the menus and no substitutions were documented. The ED stated "I saw what was for lunch yesterday and was expecting it to be what was on the menu I wrote." The ED acknowledged that they did not follow the menu and did not document substitutions prior to service. Class III .	A 093			
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. _____, 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance _____, 8. Name, address, and telephone number of next	A 162			

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A 162	Continued From page 17 of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practitioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of	A 162			

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A 162	Continued From page 18 the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____, CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.firules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive	A 162			

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A 162	Continued From page 19 meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to record the semi-annually of residents receiving assistance with the activities of daily living in 3 (Resident #1, 2 and 4) of 3 resident records reviewed. The findings included; On record review of Resident # 1 with an admission date of , revealed no were obtained at the facility during her stay. Review of the Resident Health Assessment Form (1823) dated reflects that the resident requires assistance with ambulation, bathing, grooming, toileting and transferring. On record review of Resident # 2 with	A 162			

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A 162	Continued From page 20 an admission date of _____, revealed no _____ were recorded by the facility. The 1823 dated _____ reflects that the resident requires assistance with ambulation and bathing. On _____ during a record review of Resident # 4 with an admission date of _____, revealed _____ were not obtained by the facility. The 1823 dated _____ reflects that the resident requires assistance with bathing, _____ and toileting. On _____ at 9:16 a.m. during an interview the Resident Care Coordinator, said I don't have any _____ because we don't have a scale. Class III .	A 162			