

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 4540 BEE RIDGE ROAD 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 relicensure, emergency power plan, health facility reporting system and visitation form survey was conducted on _____ through _____ at American House Sarasota, an assisted living facility in Sarasota, Florida. The following is a description of the deficiencies identified at the time of the survey .	A 000			
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 _____	A 078			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

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A 078	Continued From page 1 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. (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 staff submit a written statement	A 078			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN HOUSE SARASOTA

**4540 BEE RIDGE ROAD
SARASOTA, FL 34233**

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A 078	Continued From page 2 from a health care provider documenting the individual is free from signs/symptoms of communicable within 30 days of hire for 1 (Staff B) of 3 staff records reviewed. This has the potential to put a population at risk of developing communicable. The findings included: Review of Resident Aide Staff B's employee file on showed a hire date of . Further review of the employee file contained a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable dated , the statement was not within the required timeframe of 30 days after hire. During an interview on at 1:34 p.m., the Administrator acknowledged Staff B's documentation of freedom from communicable was not completed within the required timeframe of 30 days upon hire. Class III	A 078		