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
	AL11969862	A. BUILDING: _____ B. WING _____	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISAS DEL CARIBE ALF II	2205 SHERMONT PL BRANDON, FL 33511

(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 A biennial survey was conducted at Brisas Del Caribe II ALF on . Deficiencies were identified at the time of the survey.	A 000		
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 1 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 ensure that all direct care staff and administration had participated in elopement drills twice annually for four employees (Assistant Administrator, Staff B, C, and D) of six sampled employees.	A 032		

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A 032	Continued From page 2 Findings included: A review of elopement drills, conducted on , revealed the facility conducted elopement drills on , , and . The Assistant Administrator and Staff B, C, and D had not participated in the elopement drills. There were no other elopement drills since . During an interview on at 4:08 p.m.the Administrator confirmed that the Assistant Administrator, Staff B, C, and D had not participated in any elopement drills. Class III	A 032		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known	A 054		

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A 054	Continued From page 3 the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure primary care provider's names and telephone numbers were noted on the medication observation records for two residents (#1 and #4) of six sampled residents. Findings included: A review of medication observation records for Residents #1 and #4, conducted on , revealed that Resident #1 and #4's primary care provider's names and telephone numbers were not noted on their medication observations records. During an interview on at 4:06 p.m the Administrator agreed that Resident #1 and #4's primary care provider's names and telephone numbers were not noted on their medication observations records. Class III	A 054		

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A 085	Continued From page 4	A 085		
A 085 SS=D	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that persons responsible for the facility's food service and day-to-day supervision of the food service obtained a minimum of two-hours continuing education for nutrition and food service for one employee (Administrator) of one sampled employee. Findings included: An employee record review for the Administrator, conducted on , revealed the Administrator obtained two-hours continuing education regarding nutrition and food Service on . There were no other training certificates regarding nutrition and food service in the Administrator's employee record.	A 085		

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A 085	Continued From page 5 During an interview on /2205 at 11:15 a.m. the Administrator stated the Registered Dietician did not provide the training certificates for the most recent training. The Administrator was unable to provide the training certificate. Class III	A 085		

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CZ828	408.813(3) FS Administrative Fines; Violations 408.813 Administrative fines; violations.-As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine. (3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class violation. Unless otherwise specified by law, the amount of the fine may not exceed $500 for each violation. Unclassified violations include: (a) Violating any term or condition of a license. (b) Violating any provision of this part, authorizing statutes, or applicable rules. (c) Exceeding licensed capacity. (d) Providing services beyond the scope of the license. (e) Violating a moratorium imposed pursuant to s. 408.814. (f) Violating the parental consent requirements of s. 1014.06 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to comply with their licensed capacity of six residents. Findings included: An observations, conducted on at 9:16 a.m., revealed eight residents sitting in the room common area. An observation on at 9:35 a.m., revealed seven residents sitting in the room common area. Resident #8 was no longer anywhere in the facility. Residents #1, #2, #3, #4,	CZ828		

AHCA Form 3020-0001

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

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	Continued From page 1	CZ828		

#5, and #6 were observed throughout survey from 9:16 a.m. through 4:30 p.m..

An observation on at 10:00 a.m., revealed Resident #8's medication observation record were stored in the facility's medication record binder.

An observation on at 10:12 a.m., revealed Resident #8's medications continued be stored inside the medication cart.

A review of the facility's posted license, conducted on , revealed that the facility's licensed capacity was for six residents.

A review of the admission and discharge log, conducted on , revealed Resident #8 was admitted to the facility on and moved to the sister location next door on . There was no reason for the move noted on the admission and discharge log.
Resident #1 was admitted on .
Resident #2 was admitted on .
Resident #3 was admitted on .
Resident #4 was admitted on .
Resident #5 was admitted on .
Resident #6 was admitted on .

During an interview on at 9:40 a.m. Staff A stated that the eighth resident was Resident #8. Staff A stated that she took Resident #8 to the next door sister location because the resident was moving to that location today.

Review of Resident #8's medication record showed Resident #8's , one milligram (mg) was filled at the facility on and then refilled at the facility on .

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CZ828	Continued From page 2 A review of Resident #8's medication observation records, conducted on , revealed that Resident #8's medication observation records noted that the records were for the facility. On , Resident #8's prescribed medications were documented as given which included , / , 25/100 milligrams (mg), 150 mg, and -S 8. mg at 8:00 p.m. and , 1 mg at 10:00 p.m.. On , Resident #8's prescribed medications were documented as given which included , 1mg at 6:00 a.m. and , / , 25/100mg at 8:00 a.m.. Resident #8's medications were documented as given from through by the facility's employed Medication Technicians which included Staff A, B, and D. During an interview on at 12:07 p.m.. a Staff Member from the sister location, stated that Resident #8 was moving to the sister location today and that the move was still in progress and had not been completed. A review of the sister location's admission and discharge log, conducted on , revealed that Resident #8 was not listed as an in-house Resident of the sister location. There were seven residents that were listed as current residents of the sister location. A review of the sister location's posted license, conducted on , revealed that the sister location's licensed capacity was for six residents. A record review for Resident #8, conducted on , revealed that Resident #8's records	CZ828		

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CZ828	Continued From page 3 were located at the facility's sister location next door. Resident #8's demographic admission record sheet and health assessment form dated noted that Resident #8 was admitted to the facility which included the specific address of the facility. Resident #8's contract dated did not specify which of the two sister locations that the resident was admitted to. During an interview on at 1:38 p.m., Resident #8's Responsible Party stated that Resident #8 was a resident of the facility and was supposed to move next door to the sister location sometime today ( ). During an interview on at 10:25 a.m. the Administrator stated Resident #8 moved next door to the sister facility on during the survey. The Administrator was unable to explain the reason that the facility was over its licensed capacity since when Resident #1 was admitted as the seventh resident. (photographic evidence obtained) Unclassified	CZ828		