

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969637</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/24/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NEUROINTERNATIONAL HEALTHCARE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>60 BEARDED OAKS DR<br/>SARASOTA, FL 34232</b>                                |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                                         | Initial Comments<br><br>An unannounced complaint investigation for # 2024002198 and emergency power plan monitoring survey was conducted at Neurointernational Healthcare, LLC on<br><br>Complaint # 2024002198 was substantiated at A0032.<br><br>Deficiencies were identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A 000                                                                          |                                                                                                                          |                          |                                                        |
| A 032<br>SS=D                                                                 | 59A-36.007(7) FAC Resident Care - Elopement Standards<br><br>59A-36.007<br>(7) ELOPEMENT STANDARDS.<br>(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.<br>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), | A 032                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

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| A 032                                                                         | <p>Continued From page 1</p> <p>F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.</p> <p>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.</p> <p>(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:</p> <ol style="list-style-type: none"> <li>1. An immediate search of the facility and premises,</li> <li>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,</li> <li>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,</li> <li>4. The continued care of all residents within the facility in the event of an elopement.</li> </ol> <p>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and staff interview the facility failed to ensure that 1 (Resident #1) out of 1 Resident deemed as elopement risk had</p> | A 032                                                                          |                                                                                                                          |                          |                                                        |

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| A 032                                                                         | <p>Continued From page 2</p> <p>identification on their person that includes their name, and the facility's name, address, and telephone number.</p> <p>The findings included:</p> <p>Record review showered Resident #1 was admitted to the facility on . Further review showed Resident #1 eloped from the facility on .</p> <p>Observation on at 8:30 a.m. showed Resident #1 did not have an identification on his person that included his name, and the facility's name, address, and telephone number. Resident #1 said he remembered he left the facility it was more than a year ago. He said he left because he wanted to see he sister. Resident #1 said he did not have an identification on his person that included his name, and the facility's name, address, and telephone number. He said he did not know the facility's address, name, or phone number.</p> <p>On at 9:09 a.m., During an interview, the Administrator acknowledged Resident #1 did not have any identification on his person, which included his name, the facility's name, address, and telephone number. The Administrator said he was not aware of the regulatory requirement.</p> <p>On at 3:00 p.m. the Administrator confirmed that resident #1 did not have any identification on his person that included his name, the facility's name, address, and telephone number.</p> <p>Class III</p> | A 032                                                                          |                                                                                                                          |                          |                                                        |