

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/29/2025
NAME OF PROVIDER OR SUPPLIER THE FOUNTAINS OF HOPE			STREET ADDRESS, CITY, STATE, ZIP CODE 2250 JESUS WAY SARASOTA, FL 34240		
(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 complaint investigation #2025006354 and an emergency power plan monitoring survey was conducted at The Fountains of Hope on . Deficiencies were identified at the time of survey.	A 000			
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or	A 165			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

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A 165	Continued From page 1 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to	A 165			

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A 165	Continued From page 2 disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to submit adverse incident reports electronically to the Agency for incidents that required the transfer of the resident from the facility to a unit providing more acute care for 2 (Resident #7 and #8) of 13 incident reports reviewed. The findings included: On review of the facility's Management Policy revised , revealed: "DEFINITIONS: - defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. A person being lowered to the floor in the presence of a staff member is not considered a . PROCEDURES: . . . Post . Interventions * Observe resident for potential injuries	A 165			

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A 165	Continued From page 3 * Take appropriate action, if injuries are observed * Report to the Wellness Director * Report to the resident's representative and primary physician * will be discussed during interdisciplinary team meetings * Individual service plans will be updated to include overall interventions * Report and incidents to the proper department in accordance to all state, federal and local regulations as required. On a review of recent incident reports revealed: 1. On Resident #7 " forward out of his wheelchair, while attempting to catch himself he landed on the right side of his . . . admitted to Fruitville ER [emergency room]. . . " There was no record of an adverse incident report filed with the state. 2. On Resident #8 "was trying to get up independently from his bed and states he lost his balance and . . . taken to Doctor's Hospital for further evaluation." There was no record of an adverse incident report filed with the state. During an interview on at 11:02 a.m., the Health & Wellness Director said, "We only report to the state if there's a ." Class III	A 165			