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
	AL11969409	A. BUILDING: _____ B. WING _____	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR LIVING AT SARASOTA	5750 HONORE AVENUE 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 A complaint investigation #2025014859 was conducted at Angels Senior Living at Sarasota on . Deficiencies were identified at the time of survey. .	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to provide adequate supervision for 1 (Resident #1) of 3 residents sampled. Failure to provide adequate supervision resulted in Resident#1's heat exposure/heat and transfer to acute care facility. While Resident #1 was unsupervised, there was a high likelihood of serious injury, harm, or . The findings included: Record review revealed Resident #1 was admitted to the facility on . Per Health Assessment Form 1823 dated , Resident	A 025		

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A	Continued From page 2 #1's diagnosis included , major , , , , and accident (- medical , for). Physical or sensory limitations: Uses Wheelchair. Resident #1 also required assistance with ambulation, bathing, , grooming, toileting, and transfer. Record review showed that on at 1:36 p.m., Resident #1 was found by Licensed Practical Nurse (LPN) Staff D and the facility's Regional Director of Marketing (RDM) in the facility's outdoor patio area. Staff D's documented that Resident #1 was in his wheelchair. He was drooling, was groaning, very hot, sweaty, and had a large . Resident #1 was not responsive to touch or voice. 911 was called. Staff D noticed Resident #1's wheel chair was stuck on the side of the sidewalk and there was a large on Resident #1's (did not specify what). Activities of Daily Living log (ADL) for Resident #1 indicated that the last time he was provided Activity of Daily Living (ADL) care was at 10:00 a.m. There was no other documented observation on record for Resident #1, including the noon meal. During an interview with LPN Staff D on at 12:07 p.m. said she was going to the memory unit and she saw Resident #1. Resident #1 was facing the facility indicating he was trying to go inside. Resident #1 appeared like he was having a like activity. Resident #1 was drooling, groaning, and had labored breathing. Resident #1 had felt very hot to the touch. Resident#1 was sweating and had . Resident #1 was unresponsive to touch, and verbal commands. Resident #1's wheelchair was not on the pavement. The two wheels were not on the pavement, but on the ground by the	A 025		

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A 025	Continued From page 3 bushes. She said Resident #1 was probably going to the facility when the two wheels came off the pavement and ended up on the ground that was lower. Resident #1 would not have been able to continue moving since the 2 wheels were on the ground. She believes that because his wheels were not on the pavement, he could not self-propel his wheelchair. She assumed he was trying to place his wheelchair to the pavement and by trying that, he obtained the to his left because it was touching the bushes. Staff D said she placed Resident #1 on the ground. By that time had arrived. told Staff D Resident #1's temperature was 106 F. During an interview on at 9:20 a.m., the facility's RDM said, "I was the one that found him with [Staff D]. He was when we found him. We called 911 they were here in minutes. (Emergency management services) said his temperature was 106 F. I don't know how long [the resident] was exactly out there, but based on our investigation, the last time we had documented observation of him was during toileting care on at 10:00 a.m. So close to 10:30 a.m. We found him around 1:30 p.m., I believe. He was wearing shorts and a t-shirt. His normal routine was to go in and out. He was able to self-propel on his wheelchair." At the time of the interview the RDM said they do not have a specific policy which dictates how often staff needed to check residents either indoors or when they were sitting outside. RDM said they use the standard of practice of two-hour checks or more often if a resident's care plan indicated that. RDM said the facility did not have any log where the observations were documented.	A 025		

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A 025	Continued From page 4 During an interview on at 9:50 a.m., Caregiver Staff A said it was his first day working on the memory care unit. He did not know Resident #1. He said since it was his first day, the other two staff working with him (Staff B and C) told him to check on all the residents and provide care as needed. He said he did not know if he had an assignment. He was told by the two staff that he was to check on all the residents. He said he did not have specific training on how often to check on residents, but he used his previous experience to check every 2 hours. He did not go outside to check on Resident #1. He did not go to the facility's patio that day. A Schedule review for indicated that Staff A (hire date) was responsible for caring for Resident #1. Staff C was the other caregiver in the memory unit and Staff B was the medication technician and lead. Per written statement on record Staff B's statement indicated that she was not sure who was responsible for taking care of Resident #1. Staff B said she did not go to the courtyard to look for Resident #1. Staff B was unsure when was the last time she saw Resident #1. Per written statement on record Staff C statement indicated they did not have assignments but were splitting helping each other and she was not aware Resident #1 went outside. Staff C said she did not check to see if Resident #1 was outside. Staff C said last time she saw Resident #1 was at lunch time. During a telephone interview on at 11:36 a.m., Resident#1's family member said the facility notified her that her father was found in the facility's patio. She	A 025		

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A 025	Continued From page 5 acknowledged that the father was able to self-propel his wheelchair independently and it was his normal routine to go into the facility's patio. She said what bothered her was that no one went looking for him not even during lunch. Her father was left outside for so long unsupervised. She said her father was admitted to the hospital's where he remained for 3 days. He then moved to the main hospital floor and was discharged from the hospital on . Resident #1's family member said the doctor told her her father suffered from acute hyperthermia and heat . She said her father was in rehabilitation. She said he is not himself. He is drooling and he had never drooled before, and he has severe . . During an interview on at 12:31 p.m., the facility's Administrator said the facility's RDM notified her of the fact that Resident #1 was found outside in the patio, in the facility's memory unit. The Administrator said she does her round around 10:30 a.m. every day and at that time Resident #1 was not in the patio area. She verified that based on their investigation, the last documented observation of Resident #1 was around 10:00 a.m. when Staff A provided ADL care to the resident. The administrator said they had 3 staff working in the memory unit at the time of the incident. Staff B was the lead since Staff B was the medication technician, Staff C a caregiver, and Staff A was a new hire and was his first day on the floor. The Administrator said all staff have assignments and it is listed on the schedule, so they know what side of the memory unit were to be responsible. The Administrator said when she spoke with both Staffs B and C, they acknowledged they did not follow their assignment. Per the Administrator both staff did not know who was responsible for providing care	A 025		

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A 025	Continued From page 6 to Resident #1. The Administrator said she assumed that because Staff A was a new hire, they decided not to follow the assignment and all of them to be responsible for all 22 residents in the memory unit. The administrator said both Staff B and C were terminated immediately. The only staff still working was Staff A since it was his first day and did not know Resident #1. At the time of the interview the administrator said they do not have a specific policy that dictates how often staff needed to check residents either indoors or when they were sitting outside. The administrator said they use the standard of practice of two-hour checks or more often if a resident's care plan indicated that. The administrator said the facility did not have any log where the rounds were documented. Class II .	A 025		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility	A 030		

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A 030	Continued From page 7	A 030		

policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and
. ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own

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A 030	Continued From page 8	A 030		

sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and

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A 030	Continued From page 9 visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or	A 030		

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A 030	Continued From page 10 termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the	A 030		

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A 030	Continued From page 11 State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe	A 030		

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A 030	Continued From page 12 management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to provide adequate supervision for 1 (Resident #1) of 3 residents sampled. Failure to provide adequate supervision resulted in Resident#1's heat exposure/heat and transfer to acute care facility. While Resident #1 was unsupervised, there was a high likelihood of serious injury, harm, or . The findings included: Record review revealed Resident #1 was admitted to the facility on . Per Health Assessment Form 1823 dated , Resident #1's diagnosis included , major , , , , and accident (- medical , for). Physical or sensory limitations: Uses Wheelchair. Resident #1 also required assistance with ambulation, bathing, , grooming, toileting, and transfer. Record review showed that on at 1:36 p.m., Resident #1 was found by Licensed Practical Nurse (LPN) Staff D and the facility's Regional Director of Marketing (RDM) in the facility's outdoor patio area. Staff D's documented that Resident #1 was in his wheelchair. He was drooling, was groaning, very hot, sweaty, and had a large . Resident #1 was not responsive to touch or voice. 911 was called. Staff D noticed Resident #1's wheel chair was stuck on the side of the sidewalk and there was a large on Resident #1's (did not specify what).	A 030		

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(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 030	Continued From page 13 Activities of Daily Living Log (ADL) for Resident #1 indicated that the last time he was provided Activity of Daily Living (ADL) care was at 10:00 a.m. There was no other documented observation on record for Resident #1, including the noon meal. During an interview on at 9:20 a.m., the facility's RDM said, "I was the one that found him with [Staff D]. He was when we found him. We called 911 they were here in minutes. (Emergency management services) said his temperature was 106 F. I don't know how long [the resident] was exactly out there, but based on our investigation, the last time we had documented observation of him was during toileting care on at 10:00 a.m. So close to 10:30 a.m. We found him around 1:30 p.m., I believe. He was wearing shorts and a t-shirt. His normal routine was to go in and out. He was able to self-propel on his wheelchair." At the time of the interview the RDM said they do not have a specific policy which dictates how often staff needed to check residents either indoors or when they were sitting outside. RDM said they use the standard of practice of two hour checks or more often if a resident's care plan indicated that. RDM said the facility did not have any log where the observations were documented. During an interview with LPN Staff D on at 12:07 p.m. said she was going to the memory unit and she saw Resident 1. Resident #1 was facing the facility indicating he was trying to go inside. Resident #1 appeared like he was having like activity. Resident #1 was drooling, groaning, and had labor breathing. Resident #1 had felt very hot to the touch. Resident#1 was sweating and had .	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969409	A. BUILDING: _____ B. WING _____	10/14/2025

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A 030	Continued From page 14 Resident #1 was unresponsive to touch, and verbal commands. Resident #1's wheelchair was not on the pavement. The two wheels were not on the pavement, but on the ground by the bushes. She said Resident #1 was probably going to the facility when the two wheels came off the pavement and ended up on the ground that was lower. Resident #1 would not have been able to continue moving since the 2 wheels were on the ground. She believes that because his wheels were not on the pavement, he could not self-propel his wheelchair. She assumed he was trying to place his wheelchair to the pavement and by trying that, he obtained the to his left , because it was touching the bushes. Staff D said she placed Resident #1 on the ground. By that time had arrived. told staff D Resident #1's temperature was 106 F. A Schedule review for indicated that Staff A (hire date) was responsible for caring for Resident #1. Staff C was the other caregiver in the memory unit and Staff B was the medication technician and lead. During an interview on at 9:50 a.m., Caregiver Staff A said on it was his first day working on the memory care unit. He did not know Resident #1. He said since it was his first day, the other two staff working with him (Staff B and C) told him to check on all the residents and provide care as needed. He said he did not know if he had an assignment. He was told by the two staff that he was to check on all the residents. He said he did not have specific training on how often to check on residents, but he used his previous experience to check every 2 hours. He did not go outside to check on Resident #1. He did not go to the facility's patio that day.	A 030		

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A 030	Continued From page 15 Per written statement on record Staff B's statement indicated that she was not sure who was responsible for taking care of Resident #1. Staff B said she did not go to the courtyard to look for Resident #1. Staff B was unsure when was the last time she saw Resident #1. Per written statement on record Staff C statement indicated they did not have assignments but were splitting helping each other and she was not aware Resident #1 went outside. Staff C said she did not check to see if Resident #1 was outside. Staff C said last time she saw Resident #1 was at lunch time. During an interview on at 12:31 p.m., the facility's Administrator said the facility's RDM notified her of the fact that Resident #1 was found outside in the patio, in the facility's memory unit. The Administrator said she does her round around 10:30 a.m. every day and at that time Resident #1 was not in the patio area. She verified that based on their investigation, the last documented observation of Resident #1 was around 10:00 a.m. when Staff A provided ADL care to the resident. The administrator said they had 3 staff working in the memory unit at the time of the incident. Staff B was the lead since Staff B was the medication technician, Staff C a caregiver, and Staff A was a new hire and was his first day on the floor. The Administrator said all staff have assignments and it is listed on the schedule, so they know what side of the memory unit were to be responsible. The Administrator said when she spoke with both Staffs B and C, they acknowledged they did not follow their assignment. Per the Administrator both staff did not know who was responsible for providing care	A 030		

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A 030	Continued From page 16 to Resident #1. The Administrator said she assumed that because Staff A was a new hire, they decided not to follow the assignment and all of them to be responsible for all 22 residents in the memory unit. The administrator said both Staff B and C were terminated immediately. The only staff still working was Staff A since it was his first day and did not know Resident #1. At the time of the interview the administrator said they do not have a specific policy that dictates how often staff needed to check residents either indoors or when they were sitting outside. The administrator said they use the standard of practice of two-hour checks or more often if a resident's care plan indicated that. The administrator said the facility did not have any log where the rounds were documented. During a telephone interview on at 11:36 a.m., Resident#1's family member said the facility notified her that her father was found in the facility's patio. She acknowledged that the father was able to self-propel his wheelchair independently and it was his normal routine to go into the facility's patio. She said what bothered her was that no one went looking for him not even during lunch. Her father was left outside for so long unsupervised. She said her father was admitted to the hospital's where he remained for 3 days. He then moved to the main hospital floor and was discharged from the hospital on . Resident #1's family member said the doctor told her her father suffered from acute hyperthermia and heat . She said her father was in rehabilitation. She said he is not himself. He is drooling and he had never drooled before, and he has severe . Class II	A 030		

Agency for Health Care Administration

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