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
	AL11969594	A. BUILDING: _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT LAKEWOOD RANCH	7230 UNIVERSITY PARKWAY SARASOTA, FL 34240

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A 000	Initial Comments A change of ownership, emergency power plan monitoring, health facility reporting system, visitation form, and complaint investigation for #2025014056 and #2025014544 was conducted at Grand Living at Lakewood Ranch on through . Deficiencies were identified at the time of 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	A 032		

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A 032	Continued From page 1 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 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 observation, interview, and record review, the facility failed to identify and provide support and supervision for residents with a history of elopement for 3 (Residents #13, #6,	A 032		

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A 032	Continued From page 2 and #14) of 3 residents reviewed for elopement. The findings included: Review of III. Resident Care Standards Elopement [no date] Policy: The Community will meet Florida State Requirements while maintaining safety and knowledge of the resident's whereabouts... All Residents with documented evidence of potential elopement will have a label added to all their clothing, which includes the resident's name, community name, address, and phone number and date of birth. Should an ALF [assisted living facility] Resident not sign out of the facility's Sign-Out/Sign-In log... it is therefore understood by the Community that the Resident left The Community without following the policy and procedures. . . Definition of Elopement: Elopement is when a resident leaves the community without following its policies and procedures. 1. Review of the Sheet for Resident #13 revealed an admission date of to the ALF. Resident #13 was not admitted to the secured Memory Care Unit. The Initial Patient Intake Form revealed a move in date of . Review of the Resident Assessment Tool signed and dated by the physician on revealed on page 1 an assessment date of . The assessment on page 2 revealed Resident #13 was forgetful and needed reminders. A status exam was not indicated in the assessment. The form was not an Agency for Health Care Resident Assessment Form 1823 and did not speak to elopement or activities of daily living. Review of Resident #13's GL Assessment v2 dated , page 6, completed by the HWD	A 032		

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A 032	Continued From page 3 revealed an Elopement Risk Assessment of 0 (zero) points. The assessment revealed "Exit seeking behavior not exhibited within the last year" and "Does not ". Review of the facility admission progress note dated at 4:11 p.m. by the Health and Wellness Director (HWD) revealed Resident #13 had an episode at the previous ALF where he outside of the ALF at the golf course next door. The ALF did not know Resident #13 left the building and the resident was found 6 hours later. The family does have "find my iPhone" and an "air tag" in the resident's wallet as a precaution as this incident scared them. The HWD discussed the importance of always signing out with the front desk and wearing a pendent and carrying the iPhone with Resident #13's son and daughter. The progress note revealed Resident #13 used no assistive device (for walking). Review of the facility progress note dated at 4:40 p.m. by the HWD revealed Resident #13 was last seen at the facility approximately 2:00 p.m. Around 3:00 p.m., facility staff were unable to locate Resident #13. The resident did not sign out at the desk. Search of the premises and nearby stores was completed by all staff with inability to locate resident. The facility called 911 to report Resident #13's elopement. As the police officer arrived at the facility, a gentleman returned Resident #13 to the facility. The gentleman stated, "I went out to walk my dog, saw him and knew he was lost. I brought him into my house to cool off, and my wife offered him water." He said after Resident #13 cooled off, he noticed the name badge with the facility's name on it, so the gentleman brought Resident #13 to the facility.	A 032		

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A 032	Continued From page 4 On at 11:12 a.m. the Health and Wellness Director confirmed Resident #13 eloped from the regular ALF on . She said the family told her about the incident in the previous ALF where the resident was missing for 6 hours. She said she completed the resident assessment and documented Resident #13 was not an elopement risk. The HWD said there are no elopement risk residents in the secured memory care unit because they are in the secured unit. On at 2:03 p.m., the Memory Care Director (MCD) said all residents in the secured Memory Care Units are at risk of eloping. He said Resident #6 is at risk of eloping because she was admitted to memory care a couple months ago and appears just like any person in the general community. He said the resident dresses every day and walks without assistance. The MCD said it would be easy for the resident to blend into the general population and elope. The MCD said there was an incident with Resident #6 recently where they could not find the resident and she was not signed out in the log. He said they began the search for the resident. He said they finally reached the friend who had the resident with her. He said the incident was documented in the elopement drill. He said Memory Care Residents' clothing should be labeled with their names, the facility name, address, and telephone number. He said if they do not, that needs to be corrected. He said it is their policy. 2. Record review of the Sheet for Resident #6 revealed an admission date of to the secured Memory Care Unit 2nd floor. Diagnoses included unspecified and major , . Review of the Resident Health Assessment Form 1823 dated by the	A 032		

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A 032	Continued From page 5 Medical Doctor (MD) revealed on page 1, the resident was not an elopement risk. Special precautions were "memory care". Page 2 revealed Resident #6 could ambulate (walk) independently. On at 9:08 a.m., during an interview with Resident #6 in the 2nd floor Memory Care Unit. Resident #6 was observed to be dressed in street clothes and walking without assistance. She said she just moved in a couple of months ago. She said she is not happy at the facility but needs to be here. On from 9:16 a.m. through 9:23 a.m., during an observation of the 2nd floor Memory Care Unit along with the HWD, Resident #6's blouses in the closet and jacket she was wearing were identified with the resident's name only. They did not include the facility name, address, or telephone number. 3. Review of the Sheet for Resident #14 revealed an admission date . Resident #14 resided in the secured Memory Care Unit 2nd floor. Review of the Health Assessment Form 1823 signed and dated by the Advanced Practice Registered Nurse (APRN) on , page 1 revealed Resident #14 was not an elopement risk. or Behavioral Status included "memory , "; Special Precautions included "memory care." Page 2 revealed Resident #14 could ambulate independently. On at 9:23 a.m., observation of Resident #14 in the secured Memory Care Unit 2nd floor walking through the unit revealed the resident was wearing street clothes, shoes, lipstick, and a yellow leather purse over the . At that time, the HWD said Resident #14 is	A 032		

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A 032	Continued From page 6 and memory care adjustment has been difficult for the resident. During an observation the HWD verified Resident #14's blouses in the closet had no identification on them. 4. On at 10:08 a.m., during observation of the 1st floor Memory Care Unit, a female family member removed the key fob (a small, portable electronic device that acts like a regular key to open the door) from the nurse's desk and opened the secured unit door allowing a resident exit with 2 family members. On at 9:05 a.m., observation of the electronic key fob in the 1st floor secured Memory Care Unit revealed the fob was again positioned near the end of the nurses' desk and easily accessible to staff and family members. During observation with the MCD of electric key fob at the end of the desk in the 1st floor secured Memory Care Unit, the MCD said the electric key fob should not be used by family members to open and close the secured unit and he removed the fob from the end of the desk. Class III	A 032		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it	A 052		

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A 052	Continued From page 7 to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid	A 052		

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A 052	Continued From page 8 medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and	A 052		

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A 052	Continued From page 9 must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with	A 052		

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A 052	Continued From page 10 this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to orally advise the residents of the name and doses of medications for 4 (Residents #15, #16, #17, and #18) out of 4 residents who required assistance with medication self-administration and failed to place the medication in the of 1 (Resident #16) of 4 residents reviewed who required assistance with medication self-administration. The findings included: " . Medications - Assistance with Self-Administration of Medications [no date] Policy: The Community shall maintain Medication standards consistent with and in compliance with the minimum standards required by current Statutes and Rules. Procedures . . . All Medication Assistants and licensed Nursing Staff will follow specific protocols for assistance with self-administration in accordance with F.S.	A 052		

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A 052	Continued From page 11 Chapter 429. 1. On at 9:10 a.m., observation of Licensed Practical Nurse (LPN) Staff D assisting Resident #15 with self-administration of medication. Staff D placed the medication in the plastic cup and took them to the resident in the living room. Staff D stated, "I have your pills." Resident #15 took the pills into her and swallowed them with water. Staff D did not orally advise the resident of the medication names or doses. Review of Resident #15's Health Assessment revealed the resident required assistance with medication self-administration. The resident's medical record did not include a waiver excusing Staff D from orally advising the resident of the medication names and doses. 2. On at 9:17 a.m., observation of LPN Staff D preparing medications for Resident #16, revealed Staff D crushed the medication and mixed it in a small cup of chocolate pudding. Staff D walked to the apartment of Resident #16 who was still in bed. Staff D did not place the cup of crushed medication in chocolate pudding into the resident's so the resident could spoon it into her . Staff D administered the medications to the resident. Staff D did not orally advise the resident of the medication names or doses. Review of Resident #16's Health Assessment revealed the resident required assistance with medication self-administration, there was no order for administration of medication by a licensed nurse. The resident's medical record did not include a waiver excusing Staff D from orally advising the resident of the medication names	A 052		

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A 052	Continued From page 12 and doses. 3. On at 11:32 a.m., observation of Medication Technician Staff E assisting with medication self-administration for Resident #17 revealed Staff E placed the medication in the cup and stated, "I have the , for you, just one." Staff E did not orally advise the resident of the medication's dosage. Review of Resident #17's Health Assessment revealed the resident required assistance with medication self-administration. The resident's medical record did not include a waiver excusing Staff E from orally advising the resident of the medication names and doses. 4. On at 11:35 a.m., observation of Staff E assist with medication self-administration for Resident #18 revealed Staff E placed the medication in the cup. Staff E stated, "I have your , ." Staff E did not orally advise the resident of the medication dose. Review of Resident #18's Health Assessment revealed the resident required assistance with medication self-administration. The resident's medical record did not include a waiver excusing Staff E from orally advising the resident of the medication names and doses. On at 11:41 a.m., Staff E said she learned from her training she needed to orally advise the residents of the names and doses of the medications she is assisting with. Staff E acknowledged she did not advise the residents of the doses of their medications. On at 12:49 p.m., the Registered Nurse Health & Wellness Director (HWD) said the	A 052		

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A 052	Continued From page 13 residents do not have waivers excusing staff from orally advising residents of medication names and doses when they are assisting residents with medication self-administration. The HWD said the staff must orally advise on the names and doses of the medications. Class III	A 052		