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
	AL11911459	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BARCLAY AT SARASOTA	3260 LAKE POINTE BLVD SARASOTA, FL 34231

(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 for #2025016309 was conducted at The Barclay at Sarasota on . Deficiencies were identified at the time of survey.	A 000		
A 165 SS=E	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 7. An event that is reported to law enforcement or	A 165		

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A 165	Continued From page 1	A 165		

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 disciplinary action, in which case the provisions of

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A 165	Continued From page 2 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 interview, and record review, the facility failed to follow their plan of action developed to ensure staff responded to changes in conditions for 1 (Resident #1) of 1 resident reviewed who attempted to commit and who was previously identified at risk for . The facility failed to report within 1 business day after the occurrence of an adverse incident for 1 (Resident #1) of 1 resident reviewed who required transfer from the facility to a unit providing more acute care. The findings included: Review of Resident #1's progress notes revealed an incident note written by the Assistant Director of Nursing (ADON) on . Resident #1 was found on the floor, drooling, pants halfway down. The resident was not able to form a complete sentence or answer questions.	A 165		

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A 165	Continued From page 3 Emergency Medical System ( ) was called. When arrived Resident #1 was not responding to ( ) hits or his name. The resident was transported to the hospital. Review of progress note dated revealed Resident #1 was in the hospital on watch after he stated he took , , that was hidden in the facility apartment, with the intent to commit . Review of the adverse incident revealed the facility reported to the Agency on at 11:55 a.m., the incident involving Resident #1 that occurred on at 8:30 p.m. On at 12:26 p.m., during an interview, the Assistant Executive Director ( ) said she is in charge of both the Independent Living residents and the Assisted Living residents. The said she has known Resident #1 and his wife for years. She said Resident #1 always said he loved his wife more than she loved him. She said 4 months ago when Resident #1 was in the Independent Living apartments, his wife became ill, and Resident #1 became very depressed. Resident #1 said he wanted to kill himself. The said she called the police and Resident #1 was admitted to the hospital. She said shortly after Resident #1 was discharged from the hospital, Resident #1 and his wife moved into the Assisted Living apartment. Resident #1's wife was with him in the Assisted Living apartment for one day when she was discharged to the hospital. She said she did not realize Resident #1 was still at risk of committing despite his prior behavior. On at 12:45 p.m., during a telephone	A 165		

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interview, Resident #1's son said Resident #1 had thoughts of killing himself when he lived in the Independent Living apartment. He said the called the police and Resident #1 was admitted to the behavioral health pavilion for 8 days. The son said after Resident #1 was admitted to the Assisted Living Facility, he asked the staff to manage and assist Resident #1 with the medications because the resident was doing them incorrectly. The son said Resident #1 was upset by that and is also a very pessimistic person. The son said on Resident #1 took a large dose of sleeping pills at the Assisted Living Facility in an attempt to commit .

On at 10:52 a.m., during an interview, the Activity Director said she sat with Resident #1 during the ice cream social on . She said Resident #1 was describing how much he loved his wife and that he did not want to be here on earth without her. The Activity Director said she reported that information to the Assistant Director of Nursing (ADON).

On at 11:57 a.m., during an interview, the ADON said she worked at the facility on , the day Resident #1 tried to commit . She said no one reported to her that Resident #1 had thoughts of committing .

On at 2:07 p.m., during an interview, Licensed Practical Nurse (LPN) Staff B said on she gave Resident #1 a sleeping pill because he was going to bed for the night. Staff B said shortly after she gave Resident #1 the sleeping pill, she found the resident lying on the floor in the hallway, unresponsive. She said she called 911 and Resident #1 was transported to the hospital. Staff B said she did not receive training for risk or prevention or training

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A 165	Continued From page 5 for signs and symptoms of after the incident. On at 2:11 p.m., during an interview, Care Giver Staff C said she did not receive training for risk or prevention training or training for signs and symptoms of after the incident on . On at 2:02 p.m., during an interview, Care Giver Staff A said she worked on . She said she had not received any training or signs and symptoms of since . On at 2:21 p.m., the Director of Nursing (DON) said she was responsible for conducting training after the incident on . The DON she trained 10 staff on for what to do if they find medications in apartments for residents who self-administer their own medications and for residents who are assisted by staff with their medications. The DON said she did not conduct training for risk or prevention or training for signs and symptoms of after the incident on . On at 2:42 p.m., the Assistant Director of Nursing (ADON) said she received training on for what to do if they find medications in the apartments for residents who self-administer their own medications and for residents who are assisted by staff with their medications. She said there was no training for risk and prevention or signs and symptoms of . On at 3:01 p.m., the said they did not conduct risk or prevention training or training for signs and symptoms of altered mental	A 165		

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A 165	Continued From page 6 status in response to the incident for Resident #1 on . The stated, "The idea is to train everyone. They should have trained everyone on the staff roster." The said she was on vacation during the time of the incident. She said the DON reported the adverse incident to the Agency. The confirmed the report was submitted late and not within the regulatory requirements. Class III	A 165		