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
	AL11964934	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABOT RESERVE ON THE GREEN	4450 8TH STREET SARASOTA, FL 34232

(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 survey was conducted at Family Extended Care of Sarasota DBA Cabot Reserve on the Green on through for complaint investigation # 2025011708, 2025017518. Deficiencies were identified at the time of the survey. Class I deficiencies were found at tag A025, A030, A0077. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate correction is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The facility failed to provide proper supervision to prevent misconduct for 1 (Resident #1) out of 51 residents. Failure to provide proper supervision resulted in Resident #1 being , violated by the Facility's Maintenance Director. The facility failed to provide a safe decent, living environment free from for 1 (Resident #1) of 51 residents. The interaction between Resident #1 and the facility's Maintenance Director constitutes of a adult. Resident #1 was unable to comprehend, give consent, or protect herself from potential harm. Her vulnerability to being abused was increased. The facility's Administrator failed to perform her duties as required. The Administrator failed to provide a safe living	A 000		

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A 000	Continued From page 1 environment for 1 (Resident #1) of 51 residents. The facility Administrator failed to prevent, intervene, and put protective measures in place, resulting in a staff member , assaulting a adult with a diagnosis of , , who lacks the capacity to consent. The noncompliance began on . The census at the start of the survey was 51. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 025 SS=J	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.	A 025		

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A 025	Continued From page 2 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 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 staff interviews, the facility failed to provide proper supervision for residents to prevent misconduct for 1 (Resident #1) out of 51 residents. Failure to provide proper supervision resulted to Resident #1 being , violated by the Facility's	A 025		

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A 025	Continued From page 3 Maintenance Director. Resident #1 is a adult with a diagnosis of , , and lacks the capacity to consent. Due to her diagnosis Resident #1 has reduced ability to recognize unsafe situations, communicate distress effectively, and subsequently increases her vulnerability to report unwanted contacts. The findings included: Resident #1 was admitted to the facility on . Review of Resident #1's record revealed a Resident Health Assessment Form (1823) dated and updated included a medical diagnoses of , , , due to OD (overdose) , , ( ), , ( ), , non - self-harm, behaviors, vision loss- legally , , and communication . Further review revealed documentation of Court appointed Plenary guardianship of the person and property dated which appointed Resident #1's family member. It was updated again on and again appointed Resident #1's family member. Physician report dated / 23 indicated Resident #1 lacks capacity. The service plan for Resident #1 dated indicated 30-minute checks. There was no documentation provided which showed the checks were completed. Review of facility records revealed on at	A 025		

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A 025	Continued From page 4 around 11:40 a.m. Staff E entered Resident #1's room to complete routine rounds. Resident #1 was observed in the bathroom; the Maintenance Director was standing with his erect penis in Resident #1's . Staff E exited the room and immediately notified the Administrator. Staff E said she started yelling at the Maintenance Director. On at 9:07 a.m., Resident#1's legal guardian (LG), said she was notified of the incident immediately. Resident #1's LG said her ward has a , , ( ) and her short-term memory is nonexistent. She lacks the capacity to consent due to her , , . The LG said her ward called the Maintenance Director her boyfriend. She had never done that before, "so I don't know what to make of that, I know what happened was bad." The LG said she is responsible for making the , , and she did not schedule one with any doctor because she did not want her ward to be upset. The LG said she felt the issue was very well taken care of and she is not planning on making any doctor , , since her ward is to her baseline, she has no behaviors and she is stable. On at 9:16 a.m., the facility's Administrator said Staff E was the caregiver that found them. Resident #1 was upset when Staff E found her, and she did not understand why they stopped her. The Administrator stated, "I was so upset with him, I was so mad, I called [another state agency] and the police. He was telling me, "It was the devil that got into him." "How dare him do something like that to this girl. I was so mad at him." The Administrator said Resident #1 was taken by the police to the police station to be interviewed by a Child Protective Team (CPT)	A 025		

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A 025	Continued From page 5	A 025		

member. The Administrator said even though Resident #1 is an adult, due to her mental state she needed to be interviewed by the CPT team members. The Administrator said that Resident #1 has a private duty aide from 10 a.m. to 6 p.m. every day. When the private aid was not in the facility, they were checking Resident #1 every 2 hours. There was no documentation provided showing the 2-hour checks were completed. The Administrator said previously Resident #1 expressed her desire to have a toy, but her legal guardian refused because she thought she would get hurt using it. The Administrator said for the first few days since the incident we had the checks hourly but now she is to baseline we have gone to checking her every 2 hours. There was no supporting documentation showing the hourly checks and the checks every 2 hours were completed.

On at 9:42 a.m., Resident #1 said she did not have a boyfriend but would like one. Resident #1 said she wanted a " toy". She did not understand what the big deal was with the whole thing.

On at 9:47 a.m., during an interview caregiver/medication technician Staff D said the Maintenance Director was not allowed to go alone into any female resident rooms. Staff D said she checked on Resident #1 every 30 to 40 minutes when the private duty was not here. Staff D said she did not document the observations. Staff D stated "What happened was so weird. He never gave us a reason to believe he would be inappropriate."

On at 9:50 a.m., during an interview with medication technician/caregiver Staff B stated, "he had never done anything inappropriate to her

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A 025	Continued From page 6 or any other residents." Staff B said she checked on Resident #1 every hour or so when the private duty was not here. She said she did not document the observations. On at 9:56 a.m., during an interview Staff C said I have been working here for 8 months. Staff C said she checked on Resident #1 every hour or more often if needed when the private duty was not here. Staff C said she did not document the observations. On at 10:57 a.m., during an interview Resident #1's private duty aide stated "I started working for Resident #1 in 2023, the day she was admitted to the facility. The family directly pays me to be here from 10 a.m. to 6 p.m. The Friday before the incident, Resident #1 called the Maintenance Director her boyfriend. I told her he was married and she said he was not. I immediately went to the Administrator and told her about it. The Administrator said she told the Maintenance Director he couldn't go into her room by himself. She never called anyone her boyfriend. It was the first time. When I talked to her about the incident, she was upset that the staff interrupted them. In her mind, that was her boyfriend and she was upset that they got interrupted in an intimate moment. She never mentioned his name before that day, and I acted immediately. The private duty aide stated, "Look she is a young woman, and she wants a man in her life, she told me that. I understand it, but what he did was wrong regardless. He took advantage of her." On at 11:02 a.m., the Administrator confirmed that the Monday before the incident (the incident was on Thursday) she was told by the private duty aid that Resident #1 started	A 025		

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A 025	Continued From page 7	A 025		

calling the Maintenance Director her boyfriend. The Administrator said she had a conversation with the Maintenance Director and told him he was not to go into any female resident rooms without a witness. The Administrator said she implemented frequent checks, but there was no documentation on record indicating implementation of checks, or that she met with the Maintenance Director.

None of the staff interviewed acknowledged additional interventions and frequent checks from the Friday before the incident ( ) to the day of the incident, .

Sarasota county Sherrif's office report #25-106387 indicated that Staff E (the staff who found Resident #1) told the police officer she observed Resident #1 with the Maintenance Director for the past weeks.

On at 12:29 p.m., during an interview Staff E stated, "I was the one that found him. He knew he cannot be alone with any female resident in their rooms. That morning, I sensed something was off and he had no reason to be there, so I went to her room. I found Resident #1 sitting on the toilet seat with his erect penis in her her going and forward. She was upset and irritated that I stopped the whole thing. In her mind she had a private moment with her boyfriend." Staff E said the Friday before she began talking about him out of nowhere. That is how she is, if she liked a person let's say her caregiver, or a song, or a food, or a place she talked about it all the time. She started talking about him the Friday before out of nowhere. Then that happened on Thursday. I know she was upset because I stopped them, she was mad, but it was the right thing to do. Staff E stated, "She is

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A 025	Continued From page 8 a young woman I understand she has needs, but he took advantage of her. He is sick. I told him, "What the hell are you doing?" Staff E said she called the Administrator right away. He was freaking out; we called the police. He was ; He is in jail where he belongs. I did not tell the police officer that I saw her with him for several weeks, he misunderstood me. What I said to the police officer is that she started calling him her boyfriend for few days now, and she never done that before. I didn't say weeks I said days. He misunderstood me." None of the staff interviewed indicated more frequent checks were added between and (the day of the incident). On at 11:05 during an interview, the Administrator said the staff were already doing frequent checks on Resident #1 because of her condition. That was established from the time of admission. They were to provide 30-minute checks and that depended on the resident's and behavior each day. The staff already knew they needed to check on Resident #1 and have their , on her. That is why the staff came immediately. There was no written documentation for frequent checks for Resident #1. The statement contradicted the original statement provided on at 9:16 a.m. The Administrator said for the first few days since the incident, we had the checks hourly but now she is to baseline we went to checking on her every 2 hours. There was no supporting documentation provided for any checks on Resident #1. Record review found no evidence of interventions put into place after the Administrator was made aware of Resident#1 calling the Maintenance	A 025		

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A 025	Continued From page 9 Director her boyfriend on . Failure to provide proper supervision resulted in Resident #1 being , violated by the Facility's Maintenance Director. Class I Class I	A 025		
A 030 SS=J	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 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,	A 030		

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A 030	Continued From page 10 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 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	A 030		

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A 030	Continued From page 11 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 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	A 030		

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A 030	Continued From page 12 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 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	A 030		

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A 030	Continued From page 13	A 030		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964934	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABOT RESERVE ON THE GREEN	4450 8TH STREET SARASOTA, FL 34232

(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 14 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 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 interviews, the facility failed to provide a safe decent, living environment free from for 1 (Resident #1) of 51 residents. Resident #1 is a adult with a diagnosis of , , and lacks the capacity to consent. The interaction between Resident #1 and the	A 030		

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A 030	Continued From page 15 facility's Maintenance Director constituted of a adult. Resident #1 was unable to comprehend, give consent, or protect herself from potential harm. Her vulnerability to being abused was increased. The findings included: The Employee Code of Conduct shows the facility prohibits unwelcome advances-verbal or physical. The prevention, neglect, and , policies and procedures show there is zero tolerance for any form of , and/or of any resident. If any employee is confirmed to be , or neglecting, or a resident, that employee will be terminated immediately, and will be reported to the appropriate state departments and law enforcement. All employees are advocates for these residents. The facility training includes documentation that means any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant , to a adult's physical, mental, or emotional health. includes acts and omissions. Resident #1 was admitted to the facility on . Review of Resident #1's medical record revealed a Resident Health Assessment Form (1823) dated and updated which included medical diagnoses of , due to OD (overdose) .	A 030		

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A 030	Continued From page 16 ( ), , non - self-harm, behaviors, vision loss- legally , , and communication . Further review revealed documentation of Court appointed Plenary guardianship of the person and property dated which Appointed Resident #1's family member. It was updated and again appointed Resident #1's family member. Physician report dated / 23 indicated Resident #1 lacked capacity. The service plan for Resident #1 dated indicated 30-minute checks. There was no documentation provided which showed the checks were completed. Review of facility records revealed on at around 11:40 a.m. Staff E entered Resident #1's room to complete routine rounds. Resident #1 was observed in the bathroom; the Maintenance Director was standing with his erect penis in Resident #1's . Staff E said she started yelling at the Maintenance Director. Staff E exited the room and immediately notified the Administrator. The Administrator called the police. The Maintenance Director was on . Resident #1 was taken by the police to the Child Protective Team (CPT) for evaluation. On at 9:07 a.m., during an interview Resident#1's legal guardian said she was notified of the incident immediately. Resident #1's legal guardian said her ward has a ( ) and her short-term memory is nonexistent. She lacks the capacity to consent due to her . The legal guardian said her ward called the Maintenance Director her boyfriend and had never done that before, she stated, "So I don't know what to make	A 030		

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A 030	Continued From page 17 of that, I know what happened was bad." The legal guardian said she was responsible for making the , , and she did not schedule one with any doctor because she did not want her ward to be upset. On at 9:42 a.m., during an interview Resident #1 said she did not have a boyfriend but would like one. Resident #1 said she wanted a " toy". She did not understand what the big deal was with the whole thing. On at 9:16 a.m., the facility's Administrator said Staff E was the caregiver that found them. Resident #1 was upset when Staff E found her, and she did not understand why they stopped her. The Administrator stated, "I was so upset with him, I was so mad, I called DCF and the police. He was telling me, "It was the devil that got into him." "How dare him do something like that to this girl. I was so mad at him." The Administrator said Resident #1 was taken by the police to the police station to be interviewed by a Child Protective Team (CPT) member. The Administrator said even though Resident #1 is an adult, due to her mental state she needed to be interviewed by the CPT team members. The Administrator said Resident #1 had a private duty aid from 10 a.m. to 6 p.m. every day. When the private aid was not in the facility, they were to check on Resident#1 every 2 hours. There was no documentation provided showing the 2-hour checks were completed. The Administrator said that in the past Resident #1 expressed her desire to have a toy, but her legal guardian refused because she thought she would get hurt using it. There was no supporting documentation showing the hourly checks and the checks every 2 hours were completed.	A 030		

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A 030	Continued From page 18 On at 9:47 a.m., during an interview caregiver/medication technician Staff D said the Maintenance Director was not allowed to go alone into any female resident rooms. Staff D said she checked on Resident #1 every 30 to 40 minutes when the private duty was not here. Staff D said she did not document the observations. Staff D stated "What happened was so weird. He never gave us a reason to believe he would be inappropriate." On at 9:50 a.m., during an interview medication technician/caregiver Staff B said she checked on Resident #1 every hour or so when the private duty aid was not here. Staff B said she did not document the observations. On at 9:56 a.m., during an interview Staff C said she checked on Resident #1 every hour or more often if needed when the private duty was not here. Staff C said she did not document the observations. On at 10:57 a.m., during an interview Resident #1's private duty aide stated "I started working for Resident #1 the day she was admitted to the facility in 2023. The family pays me directly to be here from 10 a.m. to 6 p.m. The Friday before the incident, Resident #1 called the Maintenance Director, her boyfriend. I told her he was married and she said he was not. I immediately went to the Administrator and told her about it. The Administrator said she told the Maintenance Director he couldn't go into her room by himself.. When I talked to her about the incident, she was upset that the staff interrupted them. In her mind, that was her boyfriend and she was upset that they got interrupted in an intimate moment. She never mentioned his name before that day, and I acted immediately. The private duty aid stated, "Look she is a young woman, and	A 030		

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A 030	Continued From page 19 she wants a man in her life, she told me that. I understand it, but what he did was wrong regardless. He took advantage of her." On at 11:02 a.m., the Administrator confirmed the Monday before the incident (the incident was on Thursday) she was told by the private duty aid that Resident #1 started calling the Maintenance Director her boyfriend. The Administrator said she had a conversation with the Maintenance Director and told him he was not to go into any female resident rooms without a witness. The Administrator said she implemented frequent checks, but there was no documentation on record indicating implementation of the checks, or that she met with the Maintenance Director. None of the staff interviewed acknowledged additional interventions and frequent checks from the Friday before the incident ( ) to the day of the incident, Sarasota county Sherrif's office report #25-106387 indicated that Staff E (the staff who found Resident #1) told the police officer she observed Resident #1 with the Maintenance Director for the past weeks. On at 12:29 p.m., during an interview Staff E stated, "I was the one that found him. He knew he cannot be alone with any female resident in their rooms. That morning, I sensed something was off and he had no reason to be there, so I went to her room. I found Resident #1 sitting on the toilet seat with the Maintenance Director's erect penis in her her going and forward. She was upset and irritated that I stopped the whole thing. In her mind she had a private moment with her boyfriend." Staff E said the Friday before	A 030		

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A 030	Continued From page 20 Resident #1 began talking about him [maintenance Director] out of nowhere. That is how she was, if she liked a person let's say her caregiver, or a song, or a food, or a place she talked about it all the time. She started talking about him the Friday before out of nowhere. Then that happened on Thursday. I know she was upset because I stopped them, she was mad, but it was the right thing to do. Staff E stated, "She is a young woman I understand she has needs, but he took advantage of her. He is sick. I told him, "What the hell are you doing?" Staff E said she called the Administrator right away. He was freaking out that we called the police. He was ; He is in jail where he belongs On at 11:05 a.m., during an interview, the Administrator said the staff were already doing frequent checks on Resident #1 because of her condition. That was established from the time of admission. They were to provide 30-minute checks and that depended on the resident's and behavior each day. The staff already knew that they needed to check on Resident #1 and have their , on her. The Administrator said there was no evidence of written documentation for frequent checks which were completed for Resident #1. There was no documented monitoring of the Maintenance Director. There was no supporting documentation provided for any checks completed on Resident #1. Record reviews found no evidence of documentation of interventions implemented after the Administrator was made aware of Resident #1 calling the Maintenance Director her boyfriend on . There was no documented oversight or monitoring of the Maintenance Director. Failure to provide a safe living environment allowed the	A 030		

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A 030	Continued From page 21 Maintenance Director access to Resident #1 resulting in the assault of a adult. Class I	A 030		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010	A 077		

Agency for Health Care Administration

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A 077	Continued From page 22 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility	A 077		

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A 077	Continued From page 23 administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online	A 077		

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A 077	Continued From page 24 at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility's Administrator failed to perform her duties as required. The Administrator failed to provide a safe living environment for 1 (Resident #1) of 51 residents. The facility's Administrator is accountable for ensuring residents' safety, appropriate staff supervision, and a protective environment. The facility Administrator failed to prevent, intervene, and put protective measures in place, resulting in a staff member participating in a act with a adult with a diagnosis of , , who lacks the capacity to consent. The findings included: Review of the Executive Director 's job description signed and dated on /2 showed: Job Purpose: oversees day to day operations. Duties and Responsibilities: Delegates and monitors tasks and responsibilities in a reasonable manner. Implement policies and procedures, rules, and regulations in a fair and consistent manner but recognize the uniqueness of the situations. Uses effective problem -solving technique and supports and encourages collaboration. Supervises and directs departmental employees. Responsible for ensuring facilities compliance with all Federal, State and local laws, regulations, codes and internal policies. Ensures the rights of all persons at the facility are honored by actively asserting resident rights guidelines & does not wait for	A 077		

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A 077	Continued From page 25 rights to be claimed. Protects the individuals we serve from being subjected to verbal, , , , or punishment to include conducting appropriate and thorough investigations, enforcing policies, and timely follow up of unusual incident reports. Ensures safety and well-being of all residents and staff, and the overall safety of the facility. The facility's Policy Name: Risk management and Quality Assurance Policy Statement. The Executive Director's responsibility for implementing this policy includes the following: Ensure resident safety and provide care. Immediate priority is the well-being of the affected residents. Staff must provide necessary medical attention to ensure their safety. Develop and implement corrective actions. Based on the investigation, the Executive Director develops and implements corrective action plans to prevent similar incidents form reoccurring. Record review showed Resident #1 is a female, admitted to the facility on with diagnoses including , , , due to OD (overdose) , , ( ), ( ), non - self-harm, behaviors, vision loss- legally , and communication . Further review revealed documentation of Court appointed Plenary guardianship of the person and property dated which appointed Resident #1's family member. It was updated again on and again appointed Resident #1's family member. Physician report dated / 23 indicated	A 077		

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A 077	Continued From page 26 Resident #1 lacks capacity. Review of facility records revealed on at around 11:40 a.m. Staff E entered Resident #1's room to complete routine rounds. Resident #1 was observed in the bathroom; the Maintenance Director was standing with his erect penis in Resident #1's . Staff E exited the room and immediately notified the Administrator. Staff E said she started yelling at the Maintenance Director. Staff E exited the room and immediately called the Administrator. The Administrator called the police. The Maintenance Director was and terminated on . Resident #1 was taken by the police to Child Protective Team for evaluation. Service plan for Resident #1 dated indicated 30-minute checks. No documentation of checks completed was provided. On at 10:57 a.m., during an interview Resident #1's private duty aide stated "I started working for Resident #1 in 2023, the day she was admitted to the facility. The family directly pays me to be here from 10 a.m. to 6 pm. The Friday before the incident, Resident #1 called the Maintenance Director, her boyfriend. I told her he was married and she said he was not. I immediately went to the Administrator and told her about it. The Administrator said she told the Maintenance Director he couldn't go into her room by himself. She never called anyone her boyfriend. It was the first time. When I talked to her about the incident, she was upset that the staff interrupted them. In her mind, that was her boyfriend and she was upset that they got interrupted in an intimate moment. She never mentioned his name before that day, and I acted immediately. The private duty aide stated, "Look	A 077		

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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 077	Continued From page 27	A 077		

she is a young woman, and she wants a man in her life, she told me that. I understand it, but what he did was wrong regardless. He took advantage of her."

The Administrator on at 11:02 a.m. confirmed the Monday before the incident (Incident was on Thursday 11/20/25) She was told by the private duty aid that Resident #1 started calling the Maintenance Director her boyfriend. The Administrator said she had a conversation with the Maintenance Director and told him he was not to go to any female residents' rooms without a witness. The Administrator said she implemented frequent checks, but there was no documentation on record indicating implementation of the checks, or that she met with the Maintenance Director.

On at 11:05 during an interview, the Administrator said the staff were already doing frequent checks on Resident #1 because of her condition. That was established from the time of admission. They were to provide 30-minute checks and that depended on the resident's and behavior each day. The staff already knew that they needed to check on Resident #1 and have their , on her. That is why the staff came immediately. There was no written documentation for frequent checks for Resident #1. The statement contradicted the original statement provided on at 9:16 a.m. The Administrator said for the first few days since the incident, we had the checks hourly but now she was to baseline we went to checking on her every 2 hours. There was no supporting documentation provided for any checks for Resident #1
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Resident #1 is a adult with a diagnosis

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
	AL11964934	A. BUILDING: _____ B. WING _____	12/05/2025

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A 077	Continued From page 28 of , , and lacks the capacity to consent. Resident#1 was unable to comprehend, give informed consent, or protect herself from . The Administrator's failure to prevent access by the Maintenance Director to a resident contributed to the circumstances in which the nonconsensual violation occurred. Failure to provide protective measures contributed to the Maintenance Director , assaulting Resident #1 on . Class I	A 077		