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
	AL11965291	A. BUILDING: _____ B. WING _____	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODALIS TALLAHASSEE	2110 Fleischmann Road TALLAHASSEE, FL 32308

(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 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;	A 055		

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A 055	Continued From page 1 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the	A 055		

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A 055	Continued From page 2 resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based upon observations and record reviews, 1 of 1 staff observed for medication administration failed to ensure medications were appropriately stored and secured. (Staff D) The findings include: On at 09:30 AM, a medication review observation was made with Staff Member D (Medication Tech), who, while going into to give medications left the medication cart keys on top of the medication cart and left the medication cart unlocked. A second observation was made at 10:00 am for Staff Member D while going to to give medications. When she went into the room to give the medications, she left the medication cart drawer open and the keys on the top of the medication cart. After these observations, Staff Member D was asked about securing medications. She acknowledged she should have locked the cart when she was not there. Upon review of the medication tech training and policies, it reveals that medication techs are to ensure that medications are in a locked and secure area.	A 055		

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A 055	Continued From page 3 Class III	A 055		
ZZ000	Initial Comments An unannounced biennial relicensure survey, which included a generator assessment, a review of the Comprehensive Emergency Management Plan, and a complaint review of complaint #2025009683, was performed on - at Sodalis Tallahassee, an Assisted Living Facility in Tallahassee, FL. Deficient practice was found at the time of the survey.	ZZ000		
ZZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency	ZZ830		

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ZZ830	Continued From page 4	ZZ830		

management agency, county health department, or Department of Health.
(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.
(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the state of emergency.
2. Is currently licensed.
3. Does not have a provisional license.
4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.
(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any

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ZZ830	Continued From page 5 necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on document review and staff interviews, it was determined that the facility failed to resubmit its Comprehensive Emergency Management Plan (CEMP) for approval to the local emergency management agency within 30 days of the current annual plan expiration date. The findings include: A review of the CEMP revealed a letter from the local emergency management agency dated . The letter indicated that the facility's CEMP and emergency power plan had not been submitted to the Leon County Emergency Management office for review within 30 days of expiration. The current County letter of approval expired . As of , no submission had been made to the county.	ZZ830		

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ZZ830	Continued From page 6 An email was sent to the Leon County Department of Emergency Management on at approximately 11:33 AM to confirm whether the Assisted Living Facility (ALF) had submitted the CEMP plan application for review and renewal. A response was received from a representative of the Leon County Department of Emergency Management stating that the "facility is out of compliance." During an interview with the ALF Executive Director at 3:50 PM on , he stated that the plan had not been submitted to the county because the ALF was awaiting the completion of an inspection by the Leon County Fire Department. Class III	ZZ830		
A 000	Initial Comments An unannounced biennial relicensure survey, which included a generator assessment, a review of the Comprehensive Emergency Management Plan, and a complaint review of complaint #2025009683, was performed on - at Sodalis Tallahassee, an Assisted Living Facility in Tallahassee, FL. Deficient practice was found at the time of the 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	A 032		

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A 032	Continued From page 7 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 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	A 032		

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A 032	Continued From page 8 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 upon record reviews and interviews, the facility failed to properly identify and implement elopement procedures to minimize the risk of elopement for 1 of 3 residents reviewed for elopement. (Resident #11) The findings include: Upon review of facility records , Resident #11 left the facility's property on and entered the lobby of the business next door. This business contacted the facility and informed them that Resident #11 was sitting in their lobby. Facility staff assisted Resident #11 to the facility. The family of Resident #11 agreed to provide twenty-four hour supervision until Resident #11 was discharged from the facility and moved to a secured memory care unit on . It was noted that the medical review for Resident #11 was compeleted on . This form stated that Resident #11 had mild ,	A 032		

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A 032	Continued From page 9 and was not a risk for elopement. An updated review form completed on indicated a change in status of and confirmed the resident was an elopement risk. However, a review of the elopment binder revealed no resident pictures in the binder. There was no documentation to verify that any changes were made to prevent possible elopements of Resident #11 after this new diagnosis was made. An interview was conducted with interim Administrator by phone on at 1:00 pm. She stated that she recalls the incident of Resident #11 leaving the facility grounds but was not aware of the change in her status on . When asked who was responsible for reviewing the health assessment forms, she stated that either she or the Director of Wellness does this. She further stated someone should have caught that change and made necessary arrangements at that time for the resident to be discharged from our facility to a secure memory care unit. Facility policy for elopement management (dated) reveals all team members will be trained on missing resident procedures and residents who have a history of and / or a diagnosis of Alzhiemers, , organic , , , or related warrant further follow up and evaluation with their healthcare provider. If warranted, the facility will print the sheet, , and place in elopement binder. This is to be updated annually or if changes occur. Class III	A 032		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES	A 036		

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A 036	Continued From page 10 (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based upon observations and interview, 1 of 1 staff members observed for medication administration failed to perform hygiene practices while adminstering medication. (Staff D) The findings include: On at approximately 09:30 am, Staff Member D (Medication Tech) was observed with gloves on in the hallway after exiting a resident's room. She was observed walking over to the	A 036		

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A 036	Continued From page 11 medication cart, unlocking it, pulling medication cards from medication drawer, reviewing medications, pouring water in a cup, and removing a medicine cup. At this point, Staff Member D knocked on the door of , removed medications into the medicine cup, assisted with adminstering medication, and exited the room. She then helped with administration of medications for while wearing the same gloves and making no attempts to sanitize her between administrations. After these medication administrations, Staff Member D was asked about hygiene practices in the facility. She acknowledged that she should have washed her before and after passing out resident medications. A review of the medication tech training revealed that medication techs are to ensure they are properly washing their before they start medication pass and in between medication passes. Class III	A 036		