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 |
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| | AL11965739 | A. BUILDING: _____ B. WING _____ | 02/19/2026 |

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| SUNCOAST CLUB AT PRESTANCIA | 3749 SARASOTA SQUARE BLVD. SARASOTA, FL 34238 |

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| A 000 | Initial Comments<br><br>A Change of Ownership, emergency power plan monitoring, health facility reporting system and complaint survey # 2025019356 was completed at Suncoast Club at Prestancia on through . Deficiencies were identified at the time of the survey.<br>. | A 000 | | |
| A 052 SS=D | 429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin<br><br>429.256<br>(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 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.<br>(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.<br>(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 . | A 052 | | |

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| A 052 | Continued From page 1 | A 052 | | |

(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 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

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| A 052 | Continued From page 2<br>dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.<br>(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.<br><br>59A-36.008<br>(3) ASSISTANCE WITH SELF-ADMINISTRATION.<br>(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 must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.<br>(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.<br>(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.<br>(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. | A 052 | | |

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| A 052 | Continued From page 3<br>(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:<br>1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,<br>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,<br>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 this fact noted in the resident's medication record, or<br>4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.<br>(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.<br>(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.<br>(h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interview, the facility failed to ensure staff who assist with self-administration do so appropriately including orally advise of the names and doses of the medications for 8 (Resident #11, #12, #13, #14, | A 052 | | |

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| A | Continued From page 4<br><br>#15, #16, #17, and #18) of 8 residents observed. The facility failed to ensure unlicensed staff are not administering medications for 2 (Resident #13, #16). The facility failed to ensure medication opt out waivers were completed as per regulation requirements for 6 (Resident #7, #11, #12, #13, #17, and #18) of 9 residents reviewed.<br><br>The findings included:<br><br>Record review of "Policy Title: Hygiene. Policy: hygiene can be obtained by proper washing and/or the use of -based rub. hygiene will be used to aid in the prevention and spread/transmission of . Procedure:. . . 2. Caregivers and volunteers will wash their or use an -based rub:. . . e. Before assisting with medications."<br><br>Record review of "Policy Number:4.10 Subject: Assistance with Self-Administration of Medication by Unlicensed Associate. Effective date: Revised date: Purpose: To clarify assistance by Unlicensed Associates with Self-Administration of Medications in Florida facilities. . . . Procedure: . . . Assistance with self-administration includes: Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. In the presence of the resident, orally advise, opening the container, removing a prescribed amount of medication from the container, and closing the container. 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/her ."<br><br>On at 11:59 a.m., observation of Medication Tech (MT) Staff A preparing Resident | A 052 | | |

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| A | Continued From page 5<br><br>#12's , medication. Staff A went to the med cart parked in the living room area. Opened the cart, and brought up Resident #12's medication profile on the computer. Staff A removed the medications and placed the pill into a cup, walked over to Resident #12 sitting outside the dining room, and said, " . [name]" gave her the cup to take the medication. Staff A did not orally advise Resident #12 of the names and doses of the medication, did not prepare the medication in the presence of Resident #12 and no hygiene was performed. Staff A continued to the next resident.<br><br>Record review for Resident #12 revealed documentation titled Orally Advised Opted Out Waiver dated and signed on . The waiver did not identify all the medications including the names and dosages being taken by Resident #12.<br>The waiver stated: "Orally Advised Opted Out Waiver, I [Resident's typed name], wish to opt out of being orally advised of each if my medications name and dosage during assistance with self-administered medication service. I understand that I will review and sign any new dosage of changes to medication each time they occur to be compliant with the Florida Statute 429.<br>b) In the presence of the resident, confirming that the medication is intended for that residents, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount id 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 | A 052 | | |

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| A 052 | Continued From page 6<br><br>must immediately be updated each time the resident's medications or dosages<br>State Regulation Set: 4.16 ASSISTED LIVING FACILITY<br>429.256( ); 59A-36.008(3)<br>The attached current medication list in attached and has been reviewed with me.<br>Resident/POA or Legal Representative Signature, Date<br>A current medication list will be attached from the electronic record upon review and signed along with the signed waiver. Any change in the medications or dosage a new medication list will be printed out and reviewed and signed by the resident or the POA."<br><br>On at 12:10 p.m., observation of MT Staff A preparing medications for Resident #13. Staff A removed the medications from the cart, placed the pill into a cup, added 2 spoonfuls of applesauce and stirred the mixture in the cup. Staff A took the cup to Resident #13 sitting at the activity table and said, "I have your for you." Staff A then spoon fed the medication and applesauce mixture into Resident #13's with a glass of water. Staff A administered the medication, did not perform after last resident and before assisting Resident #13.<br><br>Record review for Resident #13 revealed documentation titled Orally Advised Opted Out Waiver dated and signed on . The waiver did not identify all the medications including the names and dosages being taken by Resident #13.<br><br>On at 12:20 p.m., observation of MT Staff A preparing Resident #14's . medication. Staff A placed the pill onto a cup and | A 052 | | |

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gave it to Resident #14 and said, "I have your , ." Staff A did not inform Resident #14 of the dose of medication being given.

Record review for Resident #14, revealed no documentation of a medication Opt Out Waiver onsite in the record.

On at 10:45 a.m., during an interview, the ED said they are waiting on the documentation of the Opt Out Waiver for Resident #14 as they had to reach out to the previous company that owned the facility to request a copy. The ED said she has no access to that documentation at this time. The ED confirmed there is no medication Opt Out Waiver onsite for Resident #14.

On at 8:06 a.m., observation of MT Staff B preparing medication for Resident #15. Staff B removed medication from the cart, placed the pill into a cup, took cup to Resident #15's room, and entered the room. Staff B said, "Hi [name], here is your ," and gave Resident #15 the cup. Staff B did not prepare the medication in the presence of Resident #15, no hygiene was performed, and she did not tell Resident #15 the dosage of the medication given.

Resident #15 had no documented medication Opt Out Waiver.

On at 8:08 a.m., observation of MT Staff B preparing Resident #11's medications. Staff B removed the medications from the cart and placed the pills into a souffle cup. Two Medications (Lutein and ) were not available onsite to be given to Resident #11. Staff B knocked on Resident #11's door and entered the room and gave the cup to Resident #11 telling him the name of the 4 pills in the cup. Staff B did

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not inform Resident #11 of the doses of the medications and did not inform him that 2 of his medications were not available. Staff B did not prepare the medications in the presence of Resident #11.

On at 8:10 a.m., during an interview MT Staff B confirmed the Lutein and were not available to give to Resident #11. Staff B said she called the pharmacy to reorder the meds, but they are waiting for the pharmacy for the meds to be delivered and don't have them currently.

Record review for Resident #11 revealed documentation titled Orally Advised Opted Out Waiver dated and signed on . The waiver did not identify all the medications including the names and dosages being taken by Resident #11.

On at 8:13 a.m., observation of MT Staff B preparing Resident #17's medications. Staff B opened Resident #17's profile, opened the cart and removed meds, placed pills into cup and took cup to the resident's room, knocked on door and entered the room. Staff B said, "Here are your morning pills, & inhaler." Staff B did not prepare meds in the presence of the resident and did not inform her of the names and doses of meds given.

Record review for Resident #17 revealed documentation titled Orally Advised Opted Out Waiver dated and signed on . The waiver did not identify all the medications including the names and dosages being taken by Resident #17.

On at 8:26 a.m., observation of MT Staff

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| A 052 | Continued From page 9<br><br>A preparing medications for Resident #16. Staff A prepared medication mixing it with a glass of water at the med cart parked in the hallway. Staff A poured meds into a pill cup, added 3 spoonfuls of applesauce and stirred the mixture. Staff A MT took both cups of mixture and medication mixture to resident #16 sitting at table participating in puzzle activity and spoon fed the meds in applesauce into resident #16's with water mixture. Staff A did not tell Resident #16 the names and doses of the meds given. Staff A administered (spoon fed) Resident #16 the meds and did not prepare the meds in the presence of the resident.<br><br>Resident #16 had no documented medication Opt Out Waiver.<br><br>On at 8:35 a.m., during an interview, MT Staff A said she is not sure if any of the residents have medication opt out waivers, that is something that would need to be checked with the Director of Resident Care.<br><br>On at 8:40 a.m., observation of MT Staff F preparing medications for Resident #18. Staff F opened Resident #18's profile on the computer on the med cart outside of the room in hallway and removed the med cards and placed the pills into cup. Staff F knocked on the door and entered the room and said, "I have you pills, have a seat for me, here is your water," and gave the resident the cup with the. Staff F did not tell Resident #18 the names and doses of the meds given and did not prepare the meds in the presence of the resident.<br><br>On at 8:48 a.m., during an interview, MT Staff F said she is not sure if residents have medication Opt Out Waivers, ask the DRC | A 052 | | |

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| A 052 | Continued From page 10<br>downstairs.<br><br>Record review for Resident #18 revealed documentation titled Orally Advised Opted Out Waiver dated and signed on . The waiver did not identify all the medications including the names and dosages being taken by Resident #18.<br><br>Record review for Resident #7. Revealed an admit date of . Further review revealed documentation of a Resident Health Assessment For (1823) signed and dated indicating Resident #7 needs assistance with self-administration of medications.<br><br>Resident #7 record contained documentation titled Orally Advised Opted Out Waiver dated and signed on . The waiver did not identify all the medications including the names and dosages being taken by Resident #7.<br><br>On at 9:41 a.m., during an interview, The Director of Resident Services (DRS) and the Executive Director (ED) said almost all the residents have medication Opt Out Waivers in the memory care and some Assisted Living residents have them. The DRS said the only persons that don't have medication Opt Out Waiver requested is Resident #15 and Resident #16.<br><br>On at 1:39 p.m., during an interview, the ED said "If the resident does not have a medication Opt Out Waiver the med techs are required to tell them the names and dosages of what medication they are giving and what it is for, and they do hygiene before and in between each person. The ED said all residents are offered the medication Opt Out Waivers upon move into the facility, and the DRS is responsible | A 052 | | |

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| A 052 | Continued From page 11<br><br>for making sure the waivers are kept updated.<br><br>On at 2:02 p.m., during an interview, the DRS said if the resident does not have an Opt Out Waiver the staff are to tell them what medications they are giving them, the MTs are not to spoon feed the resident their meds as when spoon feeding they are administering and not assisting, and if they are not telling the resident what they are given if they don't have an Opt Out Waiver, they are not following the facility policies. The DRS said for hygiene it is to be done before, in between and after assisting each resident with meds. The DRS said the residents are offered the medication Opt Out Waiver when they move in, and the Opt Out Waiver is only done once as she does not have the regulations as to how often the Opt Out Waiver is to be done, so the resident only does the Opt Out Waiver once upon move in, and they are then just kept in the chart.. The DRS said every 90 days she does a review of the meds. The DRS said the med list is only updated every 90 days if needed and then she puts it behind the original Opt Out Waiver that was signed at move in..<br><br>On at 2:45 during an interview, the ED and DRS acknowledged the medication Opt Out Waivers did not meet regulation requirements, as they do not list all medication names and dosages and were not immediately up-dated each time the dosage or medication changes.<br><br>Class III | A 052 | | |
| A 078 SS=D | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment, | A 078 | | |

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newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.
1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of

2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable

(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's

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| A 078 | Continued From page 13<br><br>health care provider in accordance with this rule chapter.<br>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.<br>(d) An assisted living facility ˬ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.<br>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:<br>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,<br>2. Maintain time sheets for all staff.<br>(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interviews, the facility failed to ensure employees hired submitted a written statement signed by a healthcare provider indicating freedom from signs and symptoms of communicable ˬ ( ) 60 days prior to hire or 30 days within hire, and document freedom from annually thereafter for 1 (Staff A) of 4 employee records reviewed.<br><br>The findings Included:<br><br>Record review for Staff A revealed a hire date of as a Resident Aide/Med Tech. Further review of Staff A's record revealed documentation of skin test results dated for negative | A 078 | | |

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| A 078 | Continued From page 14<br><br>results. There was no documentation of a statement from the healthcare provider indicating Staff A was free from signs and symptoms of communicable including .<br><br>On at 2:28 p.m., during an interview, the Executive Director acknowledged there was no documentation of a statement signed by the healthcare provider indicating Staff A was free from signs and symptoms of communicable including .<br><br>Class III<br>. | A 078 | | |
| A 081 SS=D | 429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service<br><br>429.52<br>(1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record.<br>(b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d).<br>(c) If an assisted living facility employee | A 081 | | |

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| A 081 | Continued From page 15 | A 081 | | |

completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a).

(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

59A-36.011
(2) STAFF PRESERVICE ORIENTATION.
(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1).
(b) New staff must complete the preservice orientation prior to interacting with residents.
(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.
(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:
1. Resident's rights; and,
2. The facility's license type and services offered by the facility.
(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or

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arrange for the following in-service training to facility staff:
(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training.
(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the

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| A 081 | Continued From page 17<br><br>following subjects:<br>1. Resident behavior and needs.<br>2. Providing assistance with the activities of daily living.<br>(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.<br>(f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.<br>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.<br>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interview, the facility failed to ensure facility employees completed in-service training required by the Florida Administrative Code within 30 days of employment and maintained completed documentation on file for 3 (Staff A, D, E) of 4 employee files reviewed.<br><br>The findings included:<br><br>Record review for Staff A revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of completion | A 081 | | |

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| A 081 | Continued From page 18<br><br>1 hour of Control training, Resident Rights and Recognizing/Reporting training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency procedures and Incident Reporting Training, Nutritional and Safe Food Handling, Elopement Response Training, and 3 hours of Activities of Daily Living (ADL) and Behavioral Needs training on file for Staff A.<br><br>Record review for Staff D revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of completion of 1 hour of Control training, Resident Rights and Recognizing/Reporting training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency procedures and Incident Reporting Training, Nutritional and Safe Food Handling, Elopement Response Training, and 3 hours of ADL and Behavioral Needs training on file for Staff D.<br><br>Record review for Staff E revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of completion of 2 hours of preservice orientation, Incident Reporting Training, Nutritional and Safe Food Handling on file for Staff E.<br><br>On at 1:17 p.m., during an interview, the Administrator said the Relias training completed by the employees is missing, it did not port over from the old company, so she put in a call into Relias to request the training certificates. The Administrator said the training certificates completed are not onsite for the employees reviewed.<br><br>On at 2:28 p.m., during an interview, the Administrator confirmed there is no documentation of training completion onsite in the | A 081 | | |

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| A 081 | Continued From page 19<br>records for the employees currently.<br><br>Class III<br>. | A 081 | | |
| A 082 SS=D | 59A-36.011(4) FAC Training - /<br>(4)<br>/<br>( / ). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interviews, the facility failed to ensure staff complete 1 hour of / training within 30 days of hire and maintain completed documentation on file for 3 (Staff A, D, E) of 4 employee records reviewed.<br><br>The findings included:<br><br>Record review for Staff A revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation for completion of 1 hour of / on file for Staff A.<br><br>Record review for Staff D revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation for completion of 1 hour of / on file for Staff D. | A 082 | | |

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| A 082 | Continued From page 20<br><br>Record review for Staff E revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation for completion of 1 hour of / on file for Staff E.<br><br>On at 1:17 p.m., during an interview the Administrator said the Relias training completed by the employees is missing, it did not port over from the old company, so she put in a call into Relias to request the training certificates. The Administrator said the training certificates completed are not onsite for the employees reviewed.<br><br>On at 2:28 p.m., During an interview, the Administrator confirmed there is no documentation of training completion onsite in the records for the employees currently.<br><br>Class III<br>. | A 082 | | |
| A 090 SS=D | 59A-36.011(11) FAC Training -<br><br>(11)<br>TRAINING.<br>(a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding<br>(b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. | A 090 | | |

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| A 090 | Continued From page 21<br><br>(c) Training shall consist of the information included in rule 59A-36.009, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interviews, the facility failed to ensure staff complete 1 hour of ( ) training within 30 days of hire based on the facility policies and procedures and maintain completed documentation on file for 3 (Staff A, D, E) of 4 employee records reviewed.<br><br>The findings included:<br><br>Record review for Staff A revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of completion of 1 hour of training based on the facility policies on file for Staff A.<br><br>Record review for Staff D revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation for completion of 1 hour of training based on the facility policies on file for Staff D.<br><br>Record review for Staff E revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation for completion of 1 hour of training based on the facility policies on file for Staff E.<br><br>On at 1:17 p.m., during an interview, the Administrator said the Relias training completed by the employees is missing, it did not port over from the old company, so she put in a call into Relias to request the training certificates. The Administrator said the training certificates completed are not onsite for the employees reviewed. | A 090 | | |

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| A 090 | Continued From page 22<br><br>On at 2:28 p.m., During an interview, the Administrator confirmed there is no documentation of training completion onsite in the records for the employees currently.<br><br>Class III<br>. | A 090 | | |
| A 091 SS=D | 59A-36.011(12) FAC Training - Documentation & Monitoring<br><br>(12) TRAINING DOCUMENTATION AND MONITORING.<br>(a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following:<br>1. The title of the training program,<br>2. The subject matter of the training program,<br>3. The training program agenda,<br>4. The number of hours of the training program,<br>5. The trainee's name, dates of participation, and location of the training program,<br>6. The training provider's name, dated signature and credentials, and professional license number, if applicable.<br>(b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule.<br>(c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory | A 091 | | |

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| A 091 | Continued From page 23<br>requirements.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interview, the facility failed to appropriately document the required training for 2 (Staff E, Executive Director) of 4 records reviewed.<br><br>The findings included:<br><br>Record review for Staff E revealed a hire date of as a Resident Aide/Med Tech. Further review revealed documentation of certificates of completion for Control, Universal Precautions, Sanitation from the facility's community specific polices and procedures, Resident Rights and , Neglect and , , Major Incident and Adverse incidents, Assistance with Activities of Daily Living (ADL) and Behavior Management. The certificates did not contain the training program agenda.<br><br>Record review for the Executive Director (ED) revealed a hire date of . Further review revealed documentation of a Certificate of Achievement for Community Specific Elopement Training which did not contain the date of participation and or the location of the training program.<br><br>On at 2:45 p.m., during an interview, the ED acknowledged the trainings documentation were missing the program agendas.<br><br>Class III<br>. | A 091 | | |

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| A 093 | Continued From page 24 | A 093 | | |
| A 093 SS=D | 59A-36.012(2) FAC Food Service - Dietary Standards<br><br>(2) DIETARY STANDARDS.<br>(a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible.<br>(b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes.<br>(c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of | A 093 | | |

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| A 093 | Continued From page 25 | A 093 | | |

the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.
1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.
2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal.

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| SUNCOAST CLUB AT PRESTANCIA | 3749 SARASOTA SQUARE BLVD. SARASOTA, FL 34238 |

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| A 093 | Continued From page 26<br><br>Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of ˻ the time between meals.<br>(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on .<br>(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, and interviews, the facility failed to have menus conspicuously posted and easily available for residents residing in the memory care unit. This has the potential to affect residents in this unit by limiting awareness of planned meals and choices. The Facility failed to offer meal variety options and failed to serve meals using appropriate eating ware.<br><br>The findings included:<br><br>On at 10:00 a.m., during the tour of the | A 093 | | |

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| A 093 | Continued From page 27<br><br>memory care dining room on the 2nd floor of the facility, observations revealed no menu posted in the memory care dining room or in the memory care unit.<br><br>On at 11:29 a.m., during an interview, Medication Tech (MT) Staff A said they usually post a menu in the memory care dining room, so residents can see what's for lunch.<br>.<br>On .26 at 11:30 a.m., during lunch service, observation of the memory care dining room revealed no menus posted in the MC dining room or in the unit. Observation revealed a therapeutic diet list for 4 residents posted on the wall in the MC dining room. Observation revealed meals were brought to the MC dining room in the hot cart, staff removed the plated meals from the cart and served it to the residents.<br>Observation of the residents revealed all were served water, with their meal, in white Styrofoam cups, no juices or other beverages were observed to be offered. Residents were also given black plastic disposable utensils to be used to eat their meal with. The memory care meal served at lunch consisted of mashed potatoes, chicken nuggets, coleslaw, all served on red porcelain plates, and fruit pie on small Styrofoam plates. Residents were not served with regular glasses and eating utensils.<br><br>On at 11:34 a.m., during an interview, Caregiver Staff D said she is serving the residents their lunch meals which consist of mashed potatoes, chicken nuggets and coleslaw.<br><br>On at 11:38 a.m., during an interview Staff A acknowledged there was no menu posted in the memory care dining room. | A 093 | | |

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| A 093 | Continued From page 28 | A 093 | | |

Review of the Facility's weekly menu for showed the meal for the lunch service consisting of green salad, popcorn chicken, mashed potatoes and gravy, southern green beans, baked roll, and strawberry rhubarb pie. Milk was to be offered at every meal.
There was no substitution for green salad, gravy, southern green beans or rolls.

On at 11:42 a.m., during an interview, Staff A could give no explanation as to why the residents were being served only water in disposable Styrofoam cups and given disposable utensils. Staff A said they always are served using disposable utensils and Styrofoam cups for the meals.

On at 11:30 a.m., observation of lunch service in the memory care dining room found no menus were posted. Observation of the lunch meal served included rice, egg roll, beef tips, and no vegetables. Residents served water for beverages, no option for juice, or milk as per menu. Observation revealed the water was served in Styrofoam cups and eating utensils were black plastic disposable forks.

Review of the facility weekly menu for showed the meal for the lunch service consisting of green salad, beef Mongolian Ramen, fluffy baked rice, stir fry vegetables, and Cherry Cobbler. Milk was to be offered at every meal. There was no substitution for the green salad or the noodles.

On at 11:40 a.m., during tour and observation of memory care dining room with the Executive Director (ED) she confirmed residents served water, no juice, with beverage served in Styrofoam cups and residents eating utensils

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| A 093 | Continued From page 29<br><br>were disposable. The ED confirmed there were no menus posted in the MC dining room. The ED said menus should be posted and the residents should have juice options. The ED said she would understand if there was an issue with the dishwashing machine then they would use disposables, but there is no issue currently, she would have to ask the Director of Dining Services about the cups and utensils being disposable.<br><br>On at 11:45 a.m., an interview was conducted with the Director of Dining Services (DDS) and the Executive Director. The DDS said he had been serving the memory care residents in Styrofoam cups for beverages and disposable utensils for a while now, he thought it would be a danger to them if they had regular utensils and cups, so he has been using the plastic utensils and foam cups for a while. The DDS said he does not know why there is no menu posted in the memory care dining room and could give no reason why the residents in the Memory Care all have been served water with no juice options. The DDS stated, "It might have been an oversight." The DDS said since working at the facility there has been no meal option menus for memory care only if the resident asks for something an alternative would be given. The DDS acknowledged with no menu posted the residents would not know what the alternative option would be.<br><br>Class III<br>. | A 093 | | |
| A 161 SS=D | 429.275(2) FS; 59A-36.015(2) FAC Records - Staff<br><br>429.275 | A 161 | | |

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| A 161 | Continued From page 30<br><br>(2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.<br><br>59A-36.015<br>(2) STAFF RECORDS.<br>(a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable:<br>1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C.,<br>2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,<br>3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C.,<br>4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C.,<br>5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C.<br>(b) The facility is not required to maintain | A 161 | | |

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| A 161 | Continued From page 31<br><br>personnel records for staff provided by a licensed staffing agency or staff employed by an entity , to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C.<br>(c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interview, the facility failed to maintain documentation of job applications with references and job descriptions for 3 (Staff A, D, E) of 4 records reviewed.<br><br>The findings included:<br><br>Record review for Staff A revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of a job description and or application with references on file for Staff A.<br><br>Record review for Staff D revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of a job description and or application with references on file for Staff D.<br><br>Record review for Staff E revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of a job description and or application with references on file for Staff E.<br><br>On at 2:28 p.m., during an interview, the | A 161 | | |

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| A 161 | Continued From page 32<br>Executive Director confirmed there is no documentation of job descriptions and applications with references on file in the records for the employees currently.<br><br>Class III<br>. | A 161 | | |

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 |
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| ZZ814 | 435.12(2)(b-d), FS Background Screening Clearinghouse<br><br>435.12 Care Provider Background Screening Clearinghouse.-<br>(2)(b) Until such time as the , are enrolled in the national retained print notification program at the Federal Bureau of Investigation:<br>1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency.<br>2. Effective , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity.<br>(c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse.<br>1. Before , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made.<br>2. Effective , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made. | ZZ814 | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| ZZ814 | Continued From page 1<br><br>(d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ᴗ , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interview, the facility failed to ensure staff have background screening employment status updated within 5 days on the Agency for Healthcare Administration (AHCA) Background Screening Clearinghouse (BGS) Roster website for 1 (Staff E) of 4 employees reviewed.<br><br>The findings included:<br><br>Record review for Staff E revealed a hire date of as a Resident Aide/Med Tech.<br>Review of the Agency for Healthcare of Administration background screening website revealed Staff E was not added to the facility roster until , 14 days after hire.<br><br>On at 1:53 p.m., during an interview, the Administrator said Corporate did the background screening for Staff E and did not add her to the roster, so she had to add her, which is why she | ZZ814 | | |

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| ZZ814 | Continued From page 2<br>was added late to the BGS Roster. The Administrator acknowledged Staff E was added late to the BGS roster.<br><br>Unclassified<br>. | ZZ814 | | |
| ZZ816 SS=D | 408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation<br><br>408.809 Background screening; prohibited offenses.-<br>(2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ˘ , to the Federal Bureau of Investigation for a national criminal history record check unless the person's ˘ , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ˘ , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ˘ , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ˘ , to the Federal Bureau of Investigation for a national criminal history record check. The ˘ , shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when | ZZ816 | | |

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| ZZ816 | Continued From page 3 | ZZ816 | | |

the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person , . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(d) Attestation of Compliance with Background

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| ZZ816 | Continued From page 4 | ZZ816 | | |

Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations.

(e) An administrator or chief financial officer must be screened and qualified prior to , , to the position.

(3) Results of Screening and Notification.

(a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal.

(b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S.

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| ZZ816 | Continued From page 5<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, and interview, the facility failed to maintain documentation of Background Screening Compliance Attestation Forms for 4 (Staff A, D, E, and Executive Director) of 4 employee records reviewed.<br><br>The findings included:<br><br>Record review for Staff A revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of Background Screening Compliance Attestation Form (AHCA form 3100-0008) on file for Staff A.<br><br>Record review for Staff D revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of Background Screening Compliance Attestation Form (AHCA form 3100-0008) on file for Staff D.<br><br>Record review for Staff E revealed a hire date of as a Resident Aide/Med Tech. Further review revealed no documentation of Background Screening Compliance Attestation Form (AHCA form 3100-0008) on file for Staff E.<br><br>Record review for the Executive Director (ED) revealed a hire date of . Further review revealed no documentation of Background Screening Compliance Attestation Form (AHCA form 3100-0008) on file for the ED.<br><br>On at 2:28 p.m., during an interview, the Executive Director confirmed there is no documentation of the Background Screening Attestations Forms on file in the staff records currently. | ZZ816 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965739 | A. BUILDING: _____ B. WING _____ | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNCOAST CLUB AT PRESTANCIA | 3749 SARASOTA SQUARE BLVD. SARASOTA, FL 34238 |

| (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 |
|---|---|---|---|---|
| ZZ816 | Continued From page 6<br>Class III<br>. | ZZ816 | | |