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
	AL11970223	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
81 OAKS SENIOR LIVING	8000 HAWKINS RD SARASOTA, FL 34241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation for # 2026003221 and an emergency power plan monitoring survey was conducted at 81 Oaks Senior Living on . Deficiencies were identified at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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A 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010		

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A [redacted] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010		

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to update residents Health Assessment Forms (1823) after a significant change (elopement risk) for 3 (Residents #3, #5, #6) of 6 resident Health Assessment Forms reviewed. The findings included: Requested and obtained a list of residents in the facility deemed as an elopement risk. The list included Resident $3, #5, and #6. Record review showed Resident #3 was admitted to the facility on and was included on the list of residents deemed as an elopement risk. Health Assessment (HA) review for Resident # 3 completed on did not indicate that Resident #3 was deemed an elopement risk. Record review showed Resident #5 was admitted to the facility on and was included on the list of residents deemed as an elopement risk. Health Assessment (HA) review for Resident # 5 completed on did not indicate that Resident #5 was deemed an elopement risk. Record review showed Resident #6 was admitted to the facility on and was included on the list of residents deemed as an elopement risk. Health Assessment (HA) review for Resident # 6 completed on did not indicate that Resident #3 was deemed as an elopement risk. During an interview the Administrator on at 3:00 p.m. confirmed Resident's #3, #5, #6 Health Assessments were not updated even	A 010		

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A 010	Continued From page 5 though they were deemed as an elopement risk. Class III	A 010		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of 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.	A 032		

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A 032	Continued From page 6 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interview that facility failed to ensure that residents deemed as an elopement risk had identification on their person that included their name, the facility's name, address, and phone number for 6 (Residents #1, #2, #3, #4, #5, #6) of 11 residents deemed as elopement risk. The findings included:	A 032		

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A 032	Continued From page 7 Missing Person Elopement; policy date . Procedure 1.a. Every resident will be screened prior to admission for severe elopement risk. Page 225 of the elopement policy (3) 59 A-36-007. As part of its resident elopement response policies and procedures, the facility must make at least at a minimum a daily effort to determine that at risk residents have identification on their person that includes their name, the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59 A-36011 (10) (a) or F.A.C. must be generally aware of the location of all residents assessed at high risk for elopement at all times. Requested and obtained a list of all residents deemed as elopement risk. The list included Residents #1, #2, #3, #4, #5, and #6, Observation in the facility's memory unit on from 9:00 to 9:30 a.m. showed Resident #1, #2, #3, #4, #5, #6, who were all deemed as elopement risk did not have identification on their person that included their name, the facility's name, address, and telephone number. Resident #2 was admitted to the facility on . Facility's elopement assessment dated indicated Resident #2 was high risk of elopement. Resident #3 was admitted to the facility on . Facility's elopement assessment dated indicated Resident #3 was high risk of elopement. Resident #4 was admitted to the facility on . Facility's elopement assessment dated indicated resident was high risk of	A 032		

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A 032	Continued From page 8 elopement. Resident #5 was admitted to the facility on . Facility's elopement assessment dated indicated Resident #5 was high risk of elopement. Resident #6 was admitted to the facility on . Facility's elopement assessment dated indicated Resident #6 was high risk of elopement. Record review revealed Resident #1 admitted to the facility on . Further review revealed the Resident Health Assessment Form completed on indicated Resident #1 was an elopement risk. No special interventions were put in place even though Resident #1 was deemed as an elopement risk. Resident #1 eloped from the facility on . During an interview on at 11:26 a.m. the Memory Care Director stated, "We do not have a system in place to monitor if residents wear their IDs. I know the staff checks on them to make sure they wear them and I do impromptu audits to ensure that residents wear their ID. No, I did not document the audits. We do not document 2-hour rounds for Resident #1. I know the staff does it, we also do counts hourly as part of the expectation, but we don't have documentation on that. We had Resident #1 in activities for better supervision from before the incident since she was deemed as elopement risk. She had a couple of incidents of exit seeking behavior, but she was redirected. We did not have any specific timeframe's indicated as to how often she was to be checked by staff." During an interview on at 11:57 a.m. Staff A said that Resident #1 did not have prior	A 032		

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A 032	Continued From page 9 exit seeking before that day. Staff A said he did not check on IDs. He said some residents may have them, but he was not sure. On at 12;30 p.m., during an interview Staff B said Resident #1 did not have any other elopements since then. They provide frequent checks all the time. Staff B said she did not check for IDs. Maybe the nurses do that. During an interview Staff C said on at 12:40 p.m. he does not check for IDs. He checks residents all the time, but not for IDs. During a follow up interview with the Memory Care Director (MCD)on at 12:57 p.m. she said she was not working for the facility when Resident #1 was admitted so she did know why the elopement risk was not addressed in the service plan. She started as memory director on . Resident #1 had a couple exit -seeking behaviors for the time she was the memory unit director and was documented on the record. The resident was redirected. The Memory Care Director said they modified Resident #1's service plan to include 2-hour checks after the elopement, but they did not have any documentation of the modified service plan. They completed hourly counts since the elopement but were not documenting them. The MCD said since the elopement the resident had a couple of incidents of exit seeking behaviors. Review of observation notes for Resident #1 showed the resident was and exit seeking on , , , . Staff redirected the resident with positive effect. On Resident #1 eloped from the memory unit. On , and record reviews showed Resident #1 had exit seeking	A 032		

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A 032	Continued From page 10 behaviors. Service plan for Resident #1 dated did not address elopement risk. Updated service plan for indicated monitor resident for agitation and restlessness. The Service Plans did not address elopement risk with interventions to prevent elopement. During an interview the Administrator on at 1:54 p.m. said as part of the initial admission process all residents are assessed for elopement utilizing the facility's elopement assessment form. If a resident is deemed as elopement risk the Health Assessment (HA) needs to be updated and proper interventions were to be put in place in the resident's service plan. In addition, the facility's software is updated to indicate "monitor" so everyone is aware of elopement risk. Since the elopement on the expectation was that staff were to conduct hourly counts and 2-hour checks for Resident#1. The Administrator said she was under the impression the Memory Care Director had the documentation since she was in charge of keeping track of the hourly checks and 2-hour monitoring for Resident #1. Class III	A 032		