08/12/2021

Agency for Health Care Adminis	stration		FORM APPROVE
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED

B MING

COMPLETED A. BUILDING: ____

NAME OF PROVIDER OR SUPPLIER

AI 11964952

STREET ADDRESS, CITY, STATE, ZIP CODE

5509 SWIFT ROAD ARDEN COURTS OF SARASOTA SARASOTA, FL 34231 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 000 Initial Comments A 000 An unannounced complaint survey #2021011172 was conducted on at Arden Courts of Sarasota, an assisted living facility in Sarasota. Florida. Complaint # 2021011172 had 2 allegations both of which were substantiated. The following is a description of the deficiencies: A 025 429,26(7) FS; 59A-36,007(1) FAC Resident Care A 025 SS=G - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to OΓ . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident 's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident 's representative or designee cannot be located or is unresponsive, the facility shall arrange with the

condition. 59A-36 007

An assisted living facility must provide care and services appropriate to the needs of residents LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

appropriate health care provider for the necessary care and services to treat the

> TITLE (X6) DATE

PRINTED: 09/28/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B MING AL11964952 08/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5509 SWIFT ROAD ARDEN COURTS OF SARASOTA SARASOTA, FL 34231 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 025 Continued From page 1 Δ 025 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 594-36 012 FAC (b) Daily observation by designated staff of the activities of the resident while on the premises. and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, quardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian. health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

Berryridge unit The findings included:

This Statute or Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to provide adequate supervision and documentation to ensure the safety and needs were met and failed to document in the resident record for 1 (Resident #1) of 8 residents on

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STATEMENT	or Health Care Adminis TOP DEFICIENCIES OF CORRECTION	tration (X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER: AL.11964952	(X2) MULTIPLE C A. BUILDING: B. WING	ONSTRUCTION	FORM (X3) DATE S COMPLI	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
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A 025	including with poor flow), (high) (rapid heartbeat out or No caregiver or nurse Resident #1's record A on A review of the Resid Form 1823 dated independent with well care (grooming), toile needed assistance with the resident Health Asserved and Resident Health Asserved and Poor Health Asserved Health	ed Resident #1 was on with diagnosis (rapid rate essential , and f proportion to activity). notes were present in after () form was completed ent Health Assessment noted the resident was king, eating, self ling and transfer, and only th bathing. An undated ssment Form 1823 dated ident 31 was still ation, toileting and transfer. at 8:57 a.m., the Executive e was at the facility on ing resident incident ceived a call at 11:05 p.m. he change of shift. The ED	A 025			

ED.

stopped.

stopping .

Staff B found Resident #1 ... down with her arms underneath her, called out to agency LPN and rolled her over to assess. Agency LPN called 911. Agency CNA Staff B stayed with the resident while agency LPN went to find the () status and call the was started, so Staff B continued

until ... arrived and determine ...

could be

arrived 11:15 p.m. and authorized

The ED said the resident was still in her day wear

Agency fr	or Health Care Adminis	tration				: 09/28/2021 APPROVE
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NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
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		SARASO	TA, FL 34231			
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A 025	Continued From page	3	A 025		1	
	and had not be chang found.	ed to night wear when				
	#1 was documented to 3:00 p.m. to 10:00 p.m for Courtyard was bla p.m. This sheet was Staff C. The sheet also documento who was on a bedhold bedroom from 3:00 p. that a blank space for as in the bedroom from from the bedroom fr	n sheet revealed Resident o be in her bedroom from n. on				
	Resident Assistant (trained with another s he first came to work. Ridge unit a few times residents as he was s faces. He verified the with pictures and info He also verified there) Staff C said he had taff for several days when He had been on the Berry s, but did not know the titll learning their names and ree was a book on the unit mation about each resident, were pictures on the walls.				
	Berry Ridge unit that in between 8 to 10 peop laundry. He verified he people to bed. He ne	people were actually on				

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mother to Tampa when he got off work. Staff C said he did not know the resident was missing until the relief staff came on duty and asked where Resident #1 was. He then checked that room and it was empty. He called the nurse who was on the other unit and began searching the unit. He verified the resident was found

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did the hourly rounds. Interview by telephone on

assisted

She verified

residents. She said during dining she asked the Dietary Aide delivering the meals, which residents were to get the specialized meals and the Dietary Aide pointed out those 3 residents to her, so she knew those 3 resident's names. Staff A said the nurse came in twice that night to pass medications. Staff A said at 7:00 p.m. she helped the 4 residents she knew get ready for bed and Staff C to get others ready for hed as

he requested. She said she did not do rounds on any resident as she did not know the residents.

Staff C was responsible for and

at 11:47 a.m.,

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
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ANDLING	DOKTO OF BARAGOTA	SARASOT	A, FL 34231			
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A 025	Continued From page	s was working both units the	A 025			
	night of She Ridge unit multiple tin check on the aides ar filling out the checks. Cloverdale unit when thought he had put the bed and 1 resident waseemed evasive. Ag Staff B responded to the courtyard area. A way and she went an her and she rushed te resident was beach and palm tree, and thought there mig resident was unrespo She called 911 gave her keys to anol ostatus. Reside said continued at the phone, until and was verified she had give verified she had give verified she had give verified she had give and so the said soon, that the said soon she was the said soon she said soon she was the said soon she said soon she was the said soon she said soon she was the said soon she said soon sh	verified she was on Benry nest to pass medications and at make sure they were She said she was on Staff C called to say he ewonop patient in the wrong as missing. She said Staff C ency LPN and agency CNA the call and went to search gency CNA Staff B went 1 other. She he are Staff B call owhere he was. The win in the mulch next to the She checked for a third the said was the said to the she checked for a many the said the s				
		igation notes completed by ff revealed. Staff C was				

statements revealed

seen by Agency LPN on the Cloverdale unit 3 times from 9:00 p.m. to 10:00 p.m. Interview on at 10:42 a.m., the ED said all the doors to the units are alarmed and will sound if someone attempts or goes out. The only door not alarmed is the kitchen door which leads directly to the courtyard area. She said witness

times that evening and had gone to the other unit. She said she reviewed the alarm reports and no

Staff C had left the unit 3

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A 025	Continued From page	6	A 025			
	Resident #1 could ha the kitchen door after C through the door. S he had falsified the R , Check-in and not actually obse hour; although he wa hourly check procedu	She said Staff C verified				
	10:09 a.m. and 10:17 Caregivers Staff E, F, and verified she walk be outside as much a H said her favorite pla bench outside (near v	at 9:50 a.m., 9:57 a.m., a.m. respectively, revealed G, and H knew Resident #1 s all the time and prefers to s possible. Caregiver Staff ace to sit was the covered where the resident was 00 p.m.).				
A 163 SS=G	429.49 FS Records - Alteration	Resident, Penalties for	A 163			Antonionanonanonanonanonanonanonanonanonano
		audulently alters, defaces, al or other record of an				

of license privileges.

assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination

This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the

Agency f	or Health Care Adminis	tration			PRINTED: 09/28/2021 FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		AL11964952	B. WING		08/12/2021
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A 163	Continued From page	7	A 163		And the second second
	checks completed the than fill out the report observations for 2 (Re residents listed on the failure lead to Reside around 9:00 p.m. to 1 was not found timely. The findings included Record review reveal admitted to the facility including with poor flow), (high (rapid heartbeat out o No caregiver or nurse Resident #1's record in A on Record review of the Checker #1 was documented with the control of the Checker #1 was documented was blank of the Checker #1 was documented was 5taff C. The sheet also document who was on a bedroic bedroom from 3:00 p.m. This sheet was 5taff C. The sheet also document who was on a bedroic bedroom from 3:00 p.m. and sheet was 5taff C. The sheet also document who was on a bedroic bedroom from 3:00 p.m. and sheet was 5taff C. The sheet also document who was on a bedroic bedroom from 3:00 p.m. and sheet was 5.00 p.m. this sheet was 5.00 p.m. and 5.00 p	ed Resident #1 was on with diagnosis ressential , and f proportion to activity). notes were present in after () form was completed Resident Hourly and is heet revealed Resident o be in her bedroom from n. on The section nk from 3:00 p.m. to 10:00 completed by resident aide hereted that Resident #2, d, was present in the m. to 10:00 p.m. Further #6 was also documented #8:300 p.m. to 10:00 p.m.			
	Interview by telephon- agency CNA Staff A s	e on at 10:52 a.m., aid she was working on			and a second

Berry Ridge that day. She arrived at 4:00 p.m., after rounds. She said she was working with Staff C. She said she had not worked at this

Agency fo	or Health Care Adminis	stration				0: 09/28/2021 1 APPROVE
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ITE, ZIP CODE		
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A 163	Continued From page	8	A 163			
	residents. She said of Dietary Alde deliverin were to get the special Aide pointed out those shew those 3 residen nurse came in twice t medications. Staff A: the 4 residents she knassisted Staff C to he requested. She sany resident as she of She verified. Staff did the hourly rounds. Interview on Staff C verified he Hourly and signing off and not a residents each hour; her the correct hourly taking the book and of documenting at that it Class II	said at 7:00 p.m. she helped new get ready for bed and o get others ready for bed as aid she did not do rounds on id not know the residents. C was responsible for and at 10:42 a.m., the ED said had falstified the Resident Check-in sheet by just tually observing the atthough he was able to tell check procedure, including observing the resident and ime.				
A 165 SS≃D	429.23(&) F Mgmt & QA; Adverse	S; 59A-36.016 FAC Risk Incident Report	A 165			

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-

(1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE S COMPLE	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
		5509 SWI	FT ROAD			
ARDEN C	OURTS OF SARASOTA	SARASO	TA, FL 34231			
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A 165	Continued From page	9	A 165			
	quickly to identify qua (2) Every facility licen required to maintain a purposes of this section incident" means: (a) An event over which exercise control rather resident 's condition in 1. 2. or darn 3. Permanent or 5. Any condition that 1 which the resident has consent, including fall directives; 6. Any condition that 1 work that is registent from the facilia acute care due to the resident of the resident of the resident of the facilia content of the facilia acute are such as the facilia acute care facilia acute care due to the resident of the facilia acute acute care due to the resident of the facilia acute care due to the resident of the facilia acute care due to the resident acute (3) License day after the incident, through the incident, through the incidents specified un incidents specified un preliminary report to 1 incidents specified un manufactured to the condition of the condition	sed under this part is diverse incident reports. For on, the term, "adverse on the term, and the term, and the term, and the term as a result of the and results in: ange; of bones or joints; equired medical attention to sinot given his or her unre to honor advanced requires the transfer of the lity to a unit providing more incident rather than the before the incident rather than the before the incident rather than the sefore the incident; or orded to law enforcement or tilgation; or notified to a second the second of the s				

(4) Licensed facilities shall provide within 15 days, through the agency 's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in

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regulatory board.

that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate

(10) The agency may adopt rules necessary to

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A 165	Continued From page	11	A 165			
	administer this section	n.				
	preliminary adverse ir section 429,23(3), F.S. 1 business day after t 59A-35.110, F.A.C., w reporting. (2) FULL ADVERSE I each adverse inciden above, the facility mus 15 days of the incider	E INCIDENT REPORT. The cided report required by 5, must be submitted within he incident pursuant to rule which requires online NCIDENT REPORT. For t reported in subsection (1), st submit a full report within it. The full report must be rule 59A-35.110, F.A.C.,				
	Based on record revie facility failed to fill a de					
	The findings included	;				
	with poor flow), (high) (rapid heartbeat out o	on with diagnosis (rapid rate essential				

Resident #1's record after

Form 1823 dated

A () form was completed A review of the Resident Health Assessment

independent with walking, , eating, self care (grooming), toileting and transfer, and only

noted the resident was

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Staff B staved with the resident doing

Interview on

at 8:57 a.m., the Executive

Director (ED) said she was here on when the missing resident incident occurred. She had received a call at 11:05 p.m. from agency LPN at the change of shift. The ED said the caregivers did rounds and found Resident #1 not in her room. Agency CNA Staff B and agency LPN searched the courtvard, while the other caregivers searched house. Agency Staff B found Resident #1 down with her arms underneath her, called out to agency LPN and rolled her over to assess. Agency LPN called 911. Agency CNA

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Agency f	for Health Care Adminis	stration				D: 09/28/2021 M APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S COMPL	
		AL11964952	B. WING		08/	12/2021
NAME OF P	PROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE		
ARDEN C	OURTS OF SARASOTA	5509 SWIF SARASOT	FT ROAD FA, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X9) COMPLETE DATE
A 165	Continued From page	e 13	A 165			
	arrived 11:15 p. When asked about fill report, ED said she investigation yet; she corporate and they di adverse incident as the premises and did not had a natural completing for s she verified that would be a succession of the completing for s she were succession of the completing for s she were succession of the completing for s she were succession of the completing for s she w	find the a and call the ED. was ntinued until e could be stopped, m, and authorized stopping liting an adverse incident add not completed her had discussed it with id not feel it rose to and he resident was never off the die from but rather When asked about tomeone who had a id be an adverse incident.				

08/13/2021

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED

A. BUILDING:

NAME OF PROVIDER OR SUPPLIER

B. WING_ STREET ADDRESS, CITY, STATE, ZIP CODE

5509 SWIFT ROAD

AL11964952

ARDEN C	DURTS OF SARASOTA	5509 SWIFT ROAD SARASOTA, FL 34231		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED B REGULATORY OR LSC IDENTIFYING INFOR	Y FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments	A 000		
	An unannounced complaint survey #202 was conducted on at Arden Cou Sarasota, an assisted living facility in Sar Florida.	rts of		
	Complaint # 2021011172 had 2 allegation of which were substantiated.	ns both		and the second s
	The following is a description of the deficit.	iencies:		ALECTRO CERCUTATION OF THE PROPERTY OF THE PRO
A 025	429.26(7) FS; 59A-36.007(1) FAC Resid - Supervision	ent Care A 025		essoratoratoratoratora
	429.26 (7) The facility shall notify a licensed phy when a resident exhibits signs of on or has a change of in order to rule out the presence of an un physiological condition that may be controlled to the presence of an un physiological condition that may be controlled to the presence of an un physiological condition is determined to facility must notify the resident 's represent an underlying condition is determined to facility must notify the resident or health care so and must assist in making necessary care and services to treat the condition. If the resident does not have a representative or designee cannot be loc is unresponsive, the facility shall arrange appropriate health care provider for the necessary care and services to treat the condition.	or condition derlying ibuting to attion station staff. If exist, the entative ervices for the ent 's atted or		
	59A-36.007 An assisted living facility must provide caservices appropriate to the needs of resi			bissosiosiosiosiosios.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 10/11/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B MING AL11964952 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5509 SWIFT ROAD ARDEN COURTS OF SARASOTA SARASOTA, FL 34231 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 025 Continued From page 1 Δ 025 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 594-36 012 FAC (b) Daily observation by designated staff of the activities of the resident while on the premises. and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, quardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian. health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

Berryridge unit The findings included:

This Statute or Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to provide adequate supervision and documentation to ensure the safety and needs were met and failed to document in the resident record for 1 (Resident #1) of 8 residents on

STATE FORM caso E08011 If continuation sheet 2 of 14

						: 10/11/2021
	for the old Cons. Adminis				FORM	APPROVED
STATEME	for Health Care Adminis it of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964952	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
					1 001	J, 202 1
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ARDEN	COURTS OF SARASOTA	5509 SWII				
		SARASO	A, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
A 025	our and a rom page		A 025			
	including with poor flow), (high) (rapid heartheat out of No caregiver or nurse Resident #1's record A on A review of the Resid Form 1823 dated independent with wall care (grooming), toile	on with diagnosis (rapid rate essential , and f proportion to activity). notes were present in				
	Resident Health Asse revealed Resident in ambul Interview on Director (ED) said she when the misso occurred. She hald re from agency LPN art said the caregivers di Resident #1 not in he and agency LPN seat the other caregivers	ssment Form 1823 dated ident 31 was still attion, toileting and transfer, at 8:57 a.m., the Executive awas at the facility on ing resident incident celeved a call at 11:05 p.m. he change of shift. The ED				

stopped. stopping .

arms underneath her, called out to agency LPN and rolled her over to assess. Agency LPN called 911. Agency CNA Staff B stayed with the resident while agency LPN went to find the) status and call the ED. was started, so Staff B continued until ... arrived and determine ...

The ED said the resident was still in her day wear

could be

arrived 11:15 p.m. and authorized

Agency f	or Health Care Adminis	tration				: 10/11/2021 I APPROVEC
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		AL11964952	B. WING		08/1	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5509 SWI	FT ROAD			
ARDEN C	OURTS OF SARASOTA	SARASO	TA, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
A 025	Continued From page	3	A 025			
	and had not be chang found.	ed to night wear when				
	#1 was documented 1 3:00 p.m. to 10:00 p.r for Courtyard was bla p.m. This sheet was Staff C. The sheet also docum who was on a bedholt bedroom from 3:00 p. that a blank space for as in the bedroom fro Interview by telephon	n sheet revealed Resident o be in her bedroom from n. on				
	trained with another's he first came to work. Ridge unit a few times residents as he was faces. He verified the with pictures and information that allow the said that on bed between 7:00 to tremember how many Berry Ridge unit that between 8 to 10 people to bed. He ne people to bed. He ne	taff for several days when He had been on the Berry s, but did not know the till learning their names and rer was a book on the unit mattion about each resident, were pictures on the walls, he was putting people to 5:00 p.m. He did not people were actually on				

mother to Tampa when he got off work. Staff C said he did not know the resident was missing until the relief staff came on duty and asked where Resident #1 was. He then checked that room and it was empty. He called the nurse who was on the other unit and began searching the unit. He verified the resident was found

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PRINTED: 10/11/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B MING AL11964952 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5509 SWIFT ROAD ARDEN COURTS OF SARASOTA SARASOTA, FL 34231 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 025 Continued From page 4 Δ 025 outside in the gated courtyard unresponsive around 11:00 p.m. at 12:05 p.m., observation of both units (Cloverdale & Berry Ridge) revealed the Medication Observation Record (MOR) book had photos of residents. Also a separate Resident Information book was kept on the desk by the computer in kitchen/dining area that holds all resident sheets with a photo of resident. Further resident charts contain a photo of resident inside front cover. A check of the Berry Ridge Resident Information book on at 11:53 am - showed a sheet & photo of Resident #1 still in book. Resident #1's chart contained a photo of the resident on inside front cover. Resident #1 was no longer in MOR book. Interview by telephone on at 10:52 a m agency CNA Staff A said she was working on Berry Ridge that day. She arrived at 4:00 p.m.. after rounds. She said she was working with Staff C. She said she had not worked at this facility for 3 to 4 months and did not know the residents. She said during dining she asked the

Dietary Aide delivering the meals, which residents were to get the specialized meals and the Dietary Aide pointed out those 3 residents to her, so she knew those 3 resident's names. Staff A said the nurse came in twice that night to pass medications. Staff A said at 7:00 p.m. she helped the 4 residents she knew get ready for bed and Staff C to get others ready for hed as assisted he requested. She said she did not do rounds on any resident as she did not know the residents. She verified Staff C was responsible for and did the hourly rounds. Interview by telephone on at 11:47 a.m.,

						: 10/11/202 APPROVE
Anonouf	or Hoolth Caro Adminio	tration			FORM	APPROVE
Agency for Health Care Administration STATEMENT OF DEPICIENCIES (X1) PROVIDENSUPPLIERCLIA AND PLAN OF CORRECTION (X2) PROVIDENSUPPLIERCLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		AL11964952			1 08/1	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
ARDEN C	OURTS OF SARASOTA	5509 SWIF				
		SARASOT	A, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
A 025	Continued From page	5	A 025			
	night of She Ridge unit multiple tin check on the aides ar filling out the checks. Cloverdale unit when thought he had put the bed and 1 resident w seemed evasive. Ag Staff B responded to the courtyard area. Away and she went an her and she rushed it resident was do beach and paim tree, and thought there mig resident was unrespo. She called 911 gave her keys to anol status. Reside said . continued a the phone, until and was verified she had give around 8:00 p.m. that in a short sleeved shi	e wrong patient in the wrong as missing. She said Staff C ancy LPN and agency CNA the call and went to search gency CNA Staff B went 1 other. She hear Staff B call where he was. The in the mulch next to the She checked for a ,				

statements revealed

seen by Agency LPN on the Cloverdale unit 3 times from 9:00 p.m. to 10:00 p.m. Interview on at 10:42 a.m., the ED said all the doors to the units are alarmed and will sound if someone attempts or goes out. The only door not alarmed is the kitchen door which leads directly to the courtyard area. She said witness

times that evening and had gone to the other unit. She said she reviewed the alarm reports and no

Staff C had left the unit 3

STATE FORM caso E08011 If continuation sheet 6 of 14

						: 10/11/2021 I APPROVEE
Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION UMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		AL11964952	B. WING		08/1	3/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ARDEN C	DURTS OF SARASOTA		IFT ROAD TA, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
A 025	Resident #1 could ha the kitchen door after C through the door. S he had falsified the R. Check-ii and not actually obse hour; although he wai hourly check procedu and observing the resthat time. Interview on	ght. She said the only way ve gotten out was through seeing or following Staff She said Staff C verified	A 025			
A 163	Alteration	Resident, Penalties for	A 163			

or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination

This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the

of license privileges.

Agonouf	or Health Care Adminis	tration				D: 10/11/2021 1 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		AL11964952	B. WING		08/1	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ARDEN COURTS OF SARASOTA			IFT ROAD DTA, FL 34231			
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A 163	checks completed the then fill out the report observations for 2 (Reresidents listed on the failure lead to Reside around 9:00 p.m. to 1 was not found timely. The findings included Record review reveal admitted to the facility including with poor flow, (high care to the facility including with poor flow), (high care to the facility including with poor flow). Record review or nurse Resident #1's record A on	e staff assigned to do hourly checks correctly rather without making the needed sedient #1 and #2) of 9 shourly check form. This nt #1 being outside from 0.00 p.m. and when	A 163			

agency CNA Staff A said she was working on Berry Ridge that day. She arrived at 4:00 p.m., after rounds. She said she was working with Staff C. She said she had not worked at this

	or Health Care Adminis	tration): 10/11/2021 1APPROVED
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLI	
		AL11964952	B. WING		08/1	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ARDEN C	DURTS OF SARASOTA	5509 SWIF				
			A, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ION SHOULD BE THE APPROPRIATE	
A 163	Continued From page		A 163			
	residents. She said of Dietary Aide deliverin were to get the special Aide pointed out those of residen nurse came in twice at medications. Staff A: the 4 residents she knessisted Staff C to he requested. She say resident as she of She verified Staff did the hourly rounds. Interview on Staff C verified he Hourly and signing off and not acresidents each hour; her the correct hourly her the correct hourly her be get the special staff and the signing off and not acresidents each hour; her the correct hourly her the correct hourly her be correct hourly her becomes and the special staff of	said at 7:00 p.m. she helped new get ready for bed and or get others ready for bed as aid she did not do rounds on id not know the residents. C was responsible for and at 10.42 a.m., the ED said had falsified the Resident Check-in sheet by just tually observing the although he was able to tell check procedure, including beserving the resident and				
A 165	429.23(&) F Mgmt & QA; Adverse	S; 59A-36.016 FAC Risk Incident Report	A 165			

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.-

(1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and

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Agonou f	or Hoolth Caro Adminio	tration				D: 10/11/2021 1 APPROVED
Agency for Health Care Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLERICLA IDENTIFICATION NUMBER: AL11964952		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		AL11964952	B. WING		08/1	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
ARDEN C	OURTS OF SARASOTA		IFT ROAD			
		SARASC	TA, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
A 165	Continued From page	9	A 165			
		on to correct and respond				TO THE PERSON NAMED IN COLUMN TO THE
	quickly to identify qua (2) Every facility licen					
		dverse incident reports. For				
		on, the term, "adverse				Carlo
	incident" means:					
		ch facility personnel could				
	exercise control rathe resident 's condition	r than as a result of the				l l
	1. : condition	and results in:				
	2. or dam	nage:				
	3. Permanent	;				
	4 or	of bones or joints;				
		required medical attention to				
	which the resident ha					
	directives:	ure to honor advanced				
		requires the transfer of the				
		lity to a unit providing more				
		incident rather than the				
	resident 's condition	before the incident; or				
		orted to law enforcement or				-
	its personnel for inves					
	the resident elopeme	nt, if the elopement places				i con
	(3) Licensed facilities					
		occurrence of an adverse				
		agency 's online portal, or if				
	the portal is offline, by	electronic mail, a				
		he agency on all adverse				Table 1
		der this section. The report				To the same of the
		ion regarding the identity of				and the same of th
	the affected resident, incident, and the state					
	investigation of the in					and the same of th
		shall provide within 15				
		ency 's online portal, or if the				The state of the s

portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in

STATE FORM 699 EO8011 If continuation sheet 10 of 14

PRINTED: 10/11/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B MING AL11964952 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5509 SWIFT ROAD ARDEN COURTS OF SARASOTA SARASOTA, FL 34231 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 165 | Continued From page 10 A 165 this section. The report must include the results of the facility 's investigation into the adverse incident. (6) neglect, or must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate. any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a

AHCA Form 3020-0001

regulatory board.

licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.

(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate

(10) The agency may adopt rules necessary to

Agency fo	or Health Care Adminis	tration): 10/11/2021 1APPROVEE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE S COMPLE		
		AL11964952	B. WING		08/1	3/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE		
APDEN C	OURTS OF SARASOTA	5509 SWIF	TROAD			
ARDENO			A, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
A 165	Continued From page	11	A 165			
	administer this section	n.				
	preliminary adverse ir section 429, 23(3), F.S. 1 business day after t 59A-35.110, F.A.C., w reporting. (2) FULL ADVERSE I each adverse inciden above, the facility mus 15 days of the incider	EINCIDENT REPORT. The ciddent report required by 5, must be submitted within he incident pursuant to rule which requires online NCIDENT REPORT. For t reported in subsection (1), st submit a full report must be rule 59A-35.110, F.A.C.,				
	Based on record revie facility failed to fill a d					
	The findings included	;				
	with poor flow), (high) (rapid heartbeat out o	on with diagnosis (rapid rate essential ,				

Resident #1's record after

Form 1823 dated

A () form was completed A review of the Resident Health Assessment

independent with walking, , eating, self care (grooming), toileting and transfer, and only

noted the resident was

STATE FORM 6550 E08011 If continuation sheet 12 of 14

PRINTED: 10/11/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B MING AL11964952 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5509 SWIFT ROAD ARDEN COURTS OF SARASOTA SARASOTA, FL 34231 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 165 | Continued From page 12 A 165 needed assistance with bathing. An undated Resident Health Assessment Form 1823 dated revealed Resident #1 was still independent in ambulation, toileting and transfer. Interview by telephone on at 11:47 a.m. Agency LPN said she was working both units the night of . . She said she was on Cloverdale unit when Staff C called to say he thought he had put the wrong patient in the wrong bed and 1 resident was missing. She said Staff C seemed evasive. Agency LPN and agency CNA Staff B responded to the call and went to search the courtyard area. Agency CNA Staff B went 1 way and she went another. She hear Staff B call her and she rushed to where he was. The resident was down in the mulch next to the beach and palm tree. She checked for a thought there might be a faint, but the resident was unresponsive and Staff B began . She called 911 and the administrator. She gave her keys to another staff to check the status. Resident #1 had a She said continued as instructed by over the phone, until arrived on site, viewed the and was stopped.

Interview on

at 8:57 a.m., the Executive

Director (ED) said she was here on when the missing resident incident occurred. She had received a call at 11:05 p.m. from agency LPN at the change of shift. The ED said the caregivers did rounds and found Resident #1 not in her room. Agency CNA Staff B and agency LPN searched the courtvard, while the other caregivers searched house. Agency Staff B found Resident #1 down with her arms underneath her, called out to agency LPN and rolled her over to assess. Agency LPN called 911. Agency CNA Staff B staved with the resident doing

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Agency f	or Health Care Adminis	tration				D: 10/11/2021 M APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
AL11964952		B. WING		08	13/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ARDEN C	OURTS OF SARASOTA	SARASC	IFT ROAD TA, FL 34231			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
A 165	Continued From page	13	A 165			
	arrived 11:15 p. When asked about fill report, ED said she h investigation yet; she corporate and they di adverse incident as the premises and did not had a natural completing for s she verified that would a she will be s	and call the ED. was and call the ED. was and call the ED. was all numbers outlined and could be stopped. In and authorized stopping an adverse incident ad not completed her had discussed it with do not feel it rose to and resident was never off the die from but rather When asked about omeone who had a do be an adverse incident.				