11/02/2021

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

AL11964375

B. WING\_ STREET ADDRESS, CITY, STATE, ZIP CODE

1959 N. HONORE AVENUE

I ANCHIN PAVILION		1959 N. HONORI SARASOTA, FL			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE: (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments  An unannounced relicensure, limited nursi services and emergency power plan monit survey was conducted on through at Anchin Pavillion, an assisted living facility Sarasota, Florida.  The following is a description of the deficient.	oring y in	00		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - S  (2) STAFF.  (a) Within 30 days after beginning employ newly hired staff must submit a written staff rom a health care provider documenting it individual does not have any signs or symy of communicable. The examination performed by the health care provider mus been conducted no earlier than 6 months t submission of the statement. Newly hired 4 does not include an employee transferring a break in service from one facility to anott when the facility is under the same managor ownership.  1. Evidence of a negative examination must be documented on an at basis. Documentation provided by the Flor Department of Health or a licensed health provider certifying that there is a shortage.  1. Evidence of a testing materials satisfies the examination requirement. An individual with a positive submit a health care provider's statement to individual does not constitute a risk of the staff	ment, ment at the rement that the	778		

AHCA Form 3020-0001

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

(X6) DATE

TITLE

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: AL11964375 B. WING \_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## 1959 N. HONORE AVENUE

ANCHIN PAVILION		N. HONORE AVENU	<u> </u>	
(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 078	Continued From page 1 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 equalifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.  (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility 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.  (e) For facilities with a licensed capacity of 17 or more residents, the facility must:  1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,  2. Maintain time sheets for all staff.  (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.  This Statute or Rule is not met as evidenced by:  Based on record review, and interview, the facility affeld to ensure that within 30 days of			
HCA Form 2	220 0004			

PRINTED: 11/23/2021 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 AL11964375 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1959 N. HONORE AVENUE ANCHIN PAVILION SARASOTA, FL 34235 SUMMARY STATEMENT OF DEFICIENCIES 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 078 Continued From page 2 Δ 078 a health care provider documenting the individual is free from signs/symptoms of communicable ..... and evidence of freedom from ( ) documented annually thereafter for 5 (Administrator, Staff D, E, F, G) of 5 employee records reviewed. The findings included: , review of the Administrators file revealed a hire date of ..... with a promotion to the Administrator on . The Administrators file contained documentation of a

initial statement signed by a health care provider on ..... indicating the Administrator was free from signs and symptoms of communicable . . . . . . . Further review of the Administrators file revealed a ( \_ ) Screening Questionnaire and Consent Form indicating a test performed on and read on ...... The Administrators file contained no further documentation annually indicating freedom from communicable

, a review of Staff D's employee file revealed a hire date of ... as a Certified Nursing Assistant (CNA). Staff D's file contained documentation of a . . . . ( . . ) Screening Questionnaire and consent Form signed that indicated that Staff D was free from signs or symptoms of communicable . . . . . There was no further documentation of evidence of freedom form

..... documented annually thereafter. On ......, a review of Staff E's employee file revealed a hire date of as a Resident Assistant ( . ). Staff E's file contained documentation of a . ( ) Screening

STATE FORM caso 4QM411 If continuation sheet 3 of 10

Agency for Health Care Adminis	stration		FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:	(X3) DATE SURVEY COMPLETED
	AL11964375	B. WING	11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## NCHIN PAVILION 1959 N. HONORE AVENUE

ANCHIN PAVILION 1959 N. HONORE AVENUE SARASOTA, FL. 34235				
(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 DEFIGIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 3  Questionnaire and consent Form signed that indicated that Staff E was free from signs or symptoms of communicable There was no further documentation of evidence of freedom form documented annually thereafter.  On a review of Staff F's employee file revealed a hire date of as a Certified Nursing Assistant (CNA). Staff F's flee contained documentation of a () Screening Questionnaire and consent Form signed that indicated that Staff F was free from signs or symptoms of communicable There was no further documentation of evidence of freedom form documented annually thereafter.  On a review of Staff G's employee file revealed a hire date of as a Certified Nursing Assistant (CNA). Staff G's employee file revealed a hire date of as a Certified Nursing Assistant (CNA). Staff G's flee contained documentation of a () Screening Questionnaire and consent Form signed by a healthcare provider, the form did not indicate Staff G's after from sign or symptoms of communicable Interview on at 10:22 a.m., Staff H confirmed the employee files do not contain evidence of documentation of freedom from annually as the facility now only does training for signs and symptoms of annually as the facility now only does training for signs and symptoms of interview on at 9:50 a.m., the Human Resources Director confirmed the Administrator file did not contain further evidence of documentation of annual freedom of communicable since the last documentation signed on	A 078		

PRINTED: 11/23/2021 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 AL11964375 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1959 N. HONORE AVENUE ANCHIN PAVILION SARASOTA, FL 34235 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 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 078 Continued From page 4 Δ 078 Class III A 081 429.52(1 & 7) FS; 59A-36.011( ...) FAC Training A 081 SS=D - Staff In-Service 429.52(1) (1) 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. (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

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(1).

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.

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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

ALTI964375

ALTI964375

AUDITIPLE CONSTRUCTION

(XC) MULTIPLE CONSTRUCTION
A BUILDING:

B. WING

11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANCHIN P	AVILION	NORE AVENU A, FL 34235	E	
(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 DEFIGIENCY)	(X5) COMPLETE DATE
A 081	Continued From page 5  (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 on properties of 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 ower.  1. Resident's rights: and, 2. The facility's license type and services offered by the facility administrators or managers shall provide or 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. Documentation of compliance with the staff training requirements.  1. Reporting adverse incidents. 2. Facility emergency procedures including to half-orient and control of the procedures incidents. 2. Facility emergency procedures including to half-orient and control of the procedure incidents.	TAG A 081		DATE
	emergency evacuation.			

PRINTED: 11/23/2021 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 AL11964375 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1959 N. HONORE AVENUE ANCHIN PAVILION SARASOTA, FL 34235 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) A nat Continued From page 6 A 081 (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:

following subjects:

1. Resident behavior and needs.

neglect, and .

offering this training.

Providing assistance with the activities of daily living.

Resident rights in an assisted living facility.
 Recognizing and reporting resident ....,

(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

... prevention policies and procedures when

. The facility must use its

(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.

(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.

 All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.

This Statute or Rule is not met as evidenced by:

All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.

		Luft.				D: 11/23/2021 1 APPROVED
	or Health Care Adminis	(X1) PROVIDER/SUPPLIER/CLIA	LOVOV MINI TIDE C	CONSTRUCTION	(X3) DATE S	HDVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	COMPL	
		AL11964375	B. WING		11/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANCHIN F	PAVILION		ONORE AVENU A, FL 34235	E		
(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 081	Continued From page	7	A 081			
	failed to ensure facilitizating required by F within 30 days of emp G) of 5 employee filed On revealed a hire date (Assistant, Staff E's file documentation of hacktivities of Daily Livit training within 30 day On revealed a hire date (Assistant, Staff E's file documentation of hex devices of Daily Livit training within 30 day Congression of Daily Livit training within 30 day Congression of Staff Congression of Staff Congression of Staff Congression of Staff Contain evidence of documpleted Elopemen trainer's name, crede and Resident Rights: "Neglect and trainer's name, hours signature.	Staff E's employee file of as a Resident fe failed to contain ing completed, 3-hour ng and Behavioral Needs s of hire as required.  Staff G's employee file of as a Certified aff G's file contained pement Policy Protocol ent Prevention and est. Staff G's life failed to ocumentation of having t Response training, with the nitals and dated signature; and Recognizing/Reporting training with the credentials and dated at 10:51 a.m., the Human				

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Class III

A 090 59A-36.011(11) FAC Training -SS=D

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A 090

PRINTED: 11/23/2021 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 AL11964375 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1959 N. HONORE AVENUE ANCHIN PAVILION SARASOTA, FL 34235 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) A 090 Continued From page 8 A non TRAINING (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 (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 within 30 days after regarding employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure facility employees complete at least one hour of training in the facility's policies and procedures regarding . . (. . ) within 30 days after employment and maintain documentation of completion for 2 (Staff F, G) of 5 employee files reviewed. The findings included:

AHCA Form 3020-0001

On , a review of Staff F's employee file

Nursing Assistant. Staff F's file contained no documentation of having completed an in service On ...... , a review of Staff G's employee file

Nursing Assistant. Staff G's file contained no documentation of having completed an in service

as a Certified

as a Certified

..... at 10:51 a.m., the Human Resources Director confirmed the findings.

revealed a hire date of

revealed a hire date of

Interview on

Agency f	or Health Care Adminis	stration				: 11/23/2021 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBERS	A. BUILDING:		COWIFE	100
		AL11964375	B. WING		11/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
ANCHIN F	PAVILION		NORE AVENU A, FL 34235	JE		
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A 090	Continued From page	9	A 090			
	Class III					

11/02/2021

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: AL11964375 B. WING \_\_

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANCHIN PAVILION

1959 N. HONORE AVENUE

ANCHIN P	AVILION	ARASOTA, FL 34235		
(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 000		Lipania and a second
	An unannounced relicensure, limited nursing services and emergency power plan monitoring survey was conducted on through at Anchin Pavillion, an assisted living facility in Sarasota, Florida.  The following is a description of the deficiencie.			nonen meneral
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment newly hired staff must submit a written statementy hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptom of communicable  The examination performed by the health care provider must have been conducted no earlier than 6 months below submission of the statement. Newly hired staff does not include an employee transferring with	ent he is ve ve		
	a break in service from one facility to another when the facility is under the same manageme or ownership.  1. Evidence of a negative examination must be documented on an annue basis. Documentation provided by the Florida Department of Health or a licensed health care	nt al		
	provider certifying that there is a shortage of testing materials satisfies the anni examination requirement. An individual with a positive test must submit a health care provider's statement that individual does not constitute a risk of	1		odnosta oda oda oda oda oda oda oda oda oda od
	If any staff member has, or is suspected of having, a communicable , such individu must be immediately removed from duties until written statement is submitted from a health ca	la		

4QM411

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

If continuation sheet 1 of 10

(X6) DATE

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: AL11964375 B. WING \_\_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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		SARASOTA, FL 34235			
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PRINTED: 11/30/2021 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 AL11964375 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1959 N. HONORE AVENUE ANCHIN PAVILION SARASOTA, FL 34235 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 078 Continued From page 2 Δ 078 a health care provider documenting the individual is free from signs/symptoms of communicable ..... and evidence of freedom from

employee records reviewed.

The findings included:

On review of the Administrators file revealed a hire date of ... with a promotion to the Administrator on ... The Administrators file contained documentation of antitial statement signed by a health care provider on indicating the Administrator was free from signs and symptoms of communicable ... Further review

for 5 (Administrator, Staff D, E, F, G) of 5

( ) documented annually thereafter

On a review of Staff D's employee file revealed a hire date of as a Certified Nursing Assistant (CNA). Staff D's file contained documentation of a Screening Questionnaire and consent Form signed that indicated that Staff D was free from signs or symptoms of communicable.

revealed a hire date of as a Resident
Assistant ( ). Staff E's file contained
documentation of a ( ) Screening

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11/02/2021

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: B. WING \_\_\_\_

NAME OF PROVIDER OR SUPPLIER

AL11964375

STREET ADDRESS, CITY, STATE, ZIP CODE

ANCHIN PAVILION		959 N. HONORE AVENUE ARASOTA, FL 34235		
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A 078	Continued From page 3	A 078		on the same
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	Questionnaire and consent Form signed that indicated that Staff F was free from signs of symptoms of communicable			AND
	On , a review of Staff G's employee file revealed a hire date of as a Certified Nursing Assistant (CNA). Staff G's file contains documentation of a ( ) Screenin Questionnaire and consent Form signed by a healthcare provider, the form did not indic Staff G was free from signs or symptoms of communicable	ed g		
	Interview on at 10:22 a.m., Staff H confirmed the employee files do not contain evidence of documentation of freedom from annually as the facility now only does training for signs and symptoms of			AND THE PROPERTY OF THE PROPER
	Interview on at 9:50 a.m., the Human Resources Director confirmed the Administrator file did not contain further evidence of documentation of annual freedom of communicable since the last documentation signed on	r		TA DATA CONTRACTOR CON

AHCA Form 3020-0001

STATE FORM 6550 4QM411 If continuation sheet 4 of 10

PRINTED: 11/30/2021 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 AL11964375 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1959 N. HONORE AVENUE ANCHIN PAVILION SARASOTA, FL 34235 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 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 078 Continued From page 4 Δ 078 Class III A 081 429.52(1 & 7) FS; 59A-36.011( ...) FAC Training A 081 - Staff In-Service 429.52(1) (1) 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. (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

(1).

training course. 59A-36.011

staff member if the training is provided in a single

(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

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Agency for Health Care Adminis	tration		TORWALL	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	AL11964375	B. WING	11/02/2021	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANCHIN PAVILION		1959 N. HONORE AVENUE SARASOTA, FL 34235		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION			(X5) COMPLETE DATE
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FU	A 081  A 081	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
	must receive a minimum of into in-service training within 30 days of employment that or the following subjects:  1. Reporting adverse incidents.  2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.	overs		

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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: AL11964375 B. WING\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANCHIN PAVILION		1959 N. HONORE AVENUE SARASOTA, FL 34235				
A 081	Continued From page 6  (c) Staff who provide direct care to residents, have not taken the core training program, sha receive a minimum of 1 hour in-service trainin 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 , prevention policies and procedures who friend this training.  (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aide trained in accordance with rule 59A-8.005.  F. A.C. must reachive 3 hours of in-service train within 30 days of employment that covers the following subjects:  1. Resident behavior and needs.  2. Providing assistance with the activities of directivities of directivities of the subject of the	II g b its an ss ming ally s not nust g				
	This Statute or Rule is not met as evidenced	by:		E A		

PRINTED: 11/30/2021 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 AL11964375 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1959 N. HONORE AVENUE ANCHIN PAVILION SARASOTA, FL 34235 (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 081 Continued From page 7 Δ 081 Based on record review, and interview, the facility failed to ensure facility employees complete training required by Florida Administrative Code within 30 days of employment, for 2 (Staff E, and G) of 5 employee files review. The findings included: On ..... , review of Staff E's employee file revealed a hire date of as a Resident Assistant. Staff E's file failed to contain documentation of having completed, 3-hour Activities of Daily Living and Behavioral Needs training within 30 days of hire as required. On , review of Staff G's employee file revealed a hire date of . . . as a Certified Nursing Assistant, Staff G's file contained documentation of Elopement Policy Protocol Attestation and Resident Prevention and Reporting Pre/Post Test. Staff G's file failed to contain evidence of documentation of having completed Elopement Response training, with the trainer's name, credentials and dated signature; and Resident Rights and Recognizing/Reporting /Neglect and training with the trainer's name, hours, credentials and dated signature. Interview on at 10:51 a.m., the Human Resources Director confirmed the findings,

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Class III

A 090 59A-36,011(11) FAC Training -

A 090

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The findings included:

, a review of Staff F's employee file revealed a hire date of as a Certified Nursing Assistant. Staff F's file contained no documentation of having completed an in service

On ......, a review of Staff G's employee file revealed a hire date of as a Certified Nursing Assistant. Staff G's file contained no documentation of having completed an in service

Interview on ...... at 10:51 a.m., the Human Resources Director confirmed the findings.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		AL11964375	B. WING		11/02/2021					
NAME OF PROVIDER OR SUPPLIER STE		STREET AD	TADDRESS, CITY, STATE, ZIP CODE							
ANCHIN PAVILION			9 N. HONORE AVENUE RASOTA, FL 34235							
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	CORRECTIVE ACTION SHOULD BE EFFERENCED TO THE APPROPRIATE					
A 090	Continued From page	9	A 090							
	Class III									