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
	AL11969703	A. BUILDING: _____ B. WING _____	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIANA OF SARASOTA	2630 UNIVERSITY PARKWAY SARASOTA, FL 34243

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A 000	Initial Comments An unannounced complaint investigation for #2025009563 and an emergency power plan monitoring survey was conducted on through at Liana of Sarasota. Complaint #2025009663 was substantiated at A032, A010. Deficiencies were identified at the time of the visit. .	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.	A 010		

AHCA Form 3020-0001

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

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A 010	Continued From page 1 (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, 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	A 010		

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A 010	Continued From page 2 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 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	A 010		

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A 010	Continued From page 3 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 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 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	A 010		

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A 010	Continued From page 4 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 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 ensure and maintain documentation of updated Resident Health Assessment Form 1823 after a significant change in condition and for residents deemed as an Elopement risk, as part of the continued residency for the appropriateness of placement in a facility for 4 (Residents #1, #5, #6, #7) of 4 residents reviewed. The Findings included: On at 10:30 a.m., during an interview Staff C said resident #1 eloped a couple months ago. Staff C said there is a list in the nurse's station with photos of the residents that are considered elopement risk. Observation with Staff C of the elopement risk list showed photos of 4 Residents, including Residents #7, #1, #5 and #6. On at 10:49 a.m., during an interview, Staff D (Med tech/caregiver supervisor) said there are 2 residents that are considered an elopement risk from what she can remember, they are Resident #1, #7 and also #6. 1. Review of Resident #1's record revealed an admission date of . Review of the Resident Health Assessment Form 1823 dated indicated Resident #1 was not an elopement risk.	A 010		

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A 010	Continued From page 5 Further review of Resident #1's record revealed progress notes dated which read: "Type of incident. Unwitnessed Elopement on . Location: outside of community, off grounds. Resident report: Alerted by phone from Manatee police that resident was found on the street, unidentified call the police that he seemed lost and . He was taken by a near by facility, no injuries or noted." Review of Resident #1 record revealed documentation of a DL Master Assessment form completed on indicating the reason for the assessment was a change of condition, New Elopement. Further review revealed documentation of an elopement assessment completed on by the Director of Health and Wellness (DHW) indicating Resident #1 eloped from the community on and was returned by the police. There was no documentation of an updated Resident Health Assessment Form 1823 for Resident #1 to indicate the change in condition for elopement and to indicate Resident #1 was an elopement risk. 2. Review of Resident #5's record revealed an admission date of . Review of the Resident Health Assessment Form 1823 dated indicated Resident #5 was not an elopement risk. Review of Resident #5 record revealed documentation of a DL Master Assessment form completed on indicating the reason for the assessment was a change of condition, due to exit seeking behavior. There was no documentation of an updated Resident Health Assessment Form 1823 for Resident #5 to indicate the change in condition for elopement risk.	A 010		

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A 010	Continued From page 6 On at 1:20 p.m., during an interview the National Clinical , (NCS) said she was at the facility the week after Resident #1 eloped and helped the previous DHW with the assessments of the residents which is how they came up with the elopement risk list. The NCS said they found 5 residents exhibiting exit seeking behaviors which included Residents #7, #6, #5 along with Resident #1 who eloped on . The NCS said she did not notify the physician so as to get a new 1823 completed to show the change in condition for elopement risk. The NCS said all residents on the elopement risk in her opinion should have an 1823 indicating they are elopement risk. On at 1:35 p.m., during an interview, the Administrator said in a perfect world all the residents deemed at risk for elopement should have an updated 1823 indicating they are elopement risk. The Administrator acknowledged no updated 1823 was completed for Resident #1 after his elopement to indicate the change in condition and elopement status and Residents #5 on the elopement risk list has no updated 1823 to indicate the elopement risk. On at 11:00 a.m., during an interview, the Administrator confirmed the residents listed on the Elopement risk list #7, #5, #6 and #1, has no updated 1823's to indicate they are elopement risk. The Administrator confirmed Resident #1's 1823 was not updated after the elopement incident for change in condition. Class III .	A 010		

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A 032	Continued From page 7	A 032		
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. 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	A 032		

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A 032	Continued From page 8 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 observation and interview, the facility failed to ensure residents deemed as an elopement risk have identification on their person that includes their name, the facility name, address and telephone number, for 4 (Residents #1, #5, #6, #7) of 4 residents deemed as an elopement risk. The facility failed to ensure direct care staff participate in 2 elopement drills annually. The findings included: On at 9:43 a.m., observation of Resident #1 in the facility hallway. Resident #1	A 032		

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A 032	Continued From page 9 had no identification on his person, to include his name, the facility name, address and telephone number. On at 10:25 a.m., during an interview, Staff C said the elopement risk residents are Resident #1, and Resident #5. Staff C said none of the residents in the unit wear identification on their person that includes their name, the facility name, address and telephone number, but they should, including the elopement risk residents, they need to have ID on their person. On at 10:30 a.m., during an interview Staff C said resident #1 eloped a couple months ago. Staff C said there is a list in the nurse's station with photos of the residents that are considered elopement risk. Observation with Staff C of the elopement list showed photos of Residents #7, #1, #5 and #6. On at 10:35 a.m., Observation with Staff C (Med Tech) of Resident #1. Staff C confirmed no ID on his person to include his name, the facility name, address and telephone number. On at 10:37 a.m., Observation with Staff C of Resident #7 showed no ID on her person. Staff C confirmed no ID on her person, that included her name, the facility name, address and telephone number. Review of Resident #6 record revealed an admission date of . Review of the Resident Health Assessment Form 1823 dated indicated Resident #6 was an elopement risk. On at 10:40 a.m., Observation with Staff AC of Resident #6 in her room laying on her bed	A 032		

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A 032	Continued From page 10	A 032		

with no ID on her person. Staff AC confirmed no ID on her person, that included her name, the facility name, address and telephone number. Med tech states Ellen likes to stay in her room late.

On at 10:49 a.m., during an Interview, Staff D supervisor/MT/CG said there are 2 residents that are considered an elopement risk from what she can remember, they are Resident #1, #7 and #6. Staff D said the residents that are elopement risk are to have ID on their ankles.

On at 10:51 a.m., observation with Staff D of Resident #1 walking in the facility hallways. Staff D confirmed no ID on his person, that included his name, the facility name, address and telephone number.

On at 1:40 p.m., during an interview, the Administrator said that all of the residents deemed as an elopement risk are to have identification on their person, they are to have bracelets on their person with their name, the facility name, address and telephone number. The Administrator acknowledged the elopement risk residents did not have ID on their person.

On at 8:39 a.m., Observation of Resident #1 the facility with belongings in his , no identification was observed on his person to include his name, the facility name, address and telephone number.

On at 8:49 a.m., during an interview, Staff B Licensed Practical Nurse (LP) said Resident #1 is the only elopement risk resident that she knows of and he eloped from the facility in this year. Staff B said none of the residents in the facility or on the elopement list wears any ID on

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A 032	Continued From page 11 their person, that includes their name, the facility name, address and telephone number. On at 9:13 a.m., during an interview Staff AC (Caregiver) said none of the residents wear any ID on their person that includes their name, facility name, address and telephone number. On at 9:35 a.m., Observation of Resident #5 sitting in the front lobby of the facility with a private duty care giver, no ID on his person. On at 9:46 a.m., during an interview, the private duty caregiver for resident #5 confirmed he had no identification on his person, to include his name, the facility name, address and telephone number. Class III .	A 032		