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
	AL11965739	A. BUILDING: _____ B. WING _____	06/24/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation for #2026007767 and #2026008584 was conducted at Suncoast Club at Prestancia on . This survey was completed in conjunction with a change of ownership revisit survey. Deficiencies were identified at the time of the survey.	A 000		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 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 develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ˘ ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;	A 165		

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6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(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 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

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A 165	Continued From page 2 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 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 regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a preliminary Adverse Incident report to the Agency within 1 business day after the occurrence of an adverse incident and a full report within 15 days, for 1 (Resident #5) of 1 record reviewed for Adverse incident reports The findings included: On , a review of Resident #5's progress notes showed that on , Resident #5 eloped and left the facility without staff knowing. Resident #5 was found at Costco across the street and returned to the facility by a family member, and was immediately transferred to the	A 165		

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A 165	Continued From page 3 facility Memory Care unit. Record review of facility records, revealed Resident #5 eloped from the facility on . Further review showed Agency for Healthcare Administration Adverse Incident preliminary report was submitted to the Agency on , at 10:00 p.m., 10 business days after the incident occurred. The full report was documented as completed on , 19 days after the incident occurrence. On , at 1:50 p.m., during an interview, the Resident Care Director said she filled out the progress note on and notated that Resident #5 had eloped on . She said she is not sure when the adverse incident was sent in because she doesn't provide those reports, the Executive Director does. On at 2:50 p.m., during an interview, the Executive Director (ED) said that she is charge of filing Adverse Incidents and knew that the Adverse Incident report was late. She said at the time, she couldn't fill one out because the platform still had the facility listed as Heron House, and she couldn't fill anything out. The ED said that she was so she called the main office and they told her that she had to fill out a request form to have the name changed. She said that the whole process took 2 days. The Ed could not explain why the report took 10 days for the preliminary report and 19 days for a full report to be submitted. The ED said that she didn't know. The Ed acknowledged the Adverse incident report was not submitted within the required timeframe.	A 165		

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