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
	AL11964934	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENOR LIVING AT SARASOTA LL	4450 8TH STREET SARASOTA, FL 34232

(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 #202611457, #202610109. was conducted at Best Care Senior Living on through . Deficiencies were identified at the time of the survey. Class I deficiencies were found at tag A030, A032. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate correction is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The Facility failed to ensure each resident's right to a safe environment for 1 (Resident #1) of 7 residents identified as an elopement risk. Failure to ensure a safe environment to prevent elopement for Resident #1 lead to the resident eloping from the facility and Subsequent . The Facility failed to ensure each resident at risk for elopement is assessed appropriately and develop a plan, and ensure a safe environment, and maintain a general awareness of residents' whereabouts to prevent elopement for 1 (Resident #1) of 7 residents identified elopement risk. Failure to assess appropriately and develop a plan to prevent elopement behavior of Resident #1 lead to the resident eloping from the facility and subsequent . The Facility failed to ensure residents deemed an elopement risk, have identification on their persons to include their name, the facility's name, address, and telephone number for 6 (Residents	A 000		

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A	Continued From page 1 # 2, #3, #4, #5, #6, and #7) of 6 residents deemed an elopement risk. Failure to provide adequate supervision allowed residents to elope. The noncompliance began on . . . The census at the start of the survey was 50.	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The	A 030		

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A 030	Continued From page 2	A 030		

telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and
, ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there

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must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or

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attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the

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A 030	Continued From page 5	A 030		

resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(f) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a

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A 030	Continued From page 6 resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review, observation and interviews, the Facility failed to ensure each resident's right to a safe environment for 1 (Resident #1) of 7 residents identified as an elopement risk. Failure to ensure a safe environment to prevent elopement for Resident #1 led to the resident eloping from the facility and Subsequent .	A 030		

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A 030	Continued From page 7 The findings included: 1. Resident #1 was last seen at 8:30 a.m. by staff after breakfast on . Approximately around 1:30 p.m. while looking for the Maintenance Director, the Administrator noticed an open window on the 200 wing, on the outside of the facility, with a bedspread along the ground and over the window. The Administrator and the Maintenance man went into the building and found the door of locked. Upon unlocking the door and entering, there was no sign of Resident #1. The facility began its elopement protocol and began to search the facility and the surrounding area. Resident #1 was able to open an unsecured window in and eloped from the facility, with staff unaware of the event. Record review revealed Resident #1 was admitted to the facility on . Resident #1 eloped on sometime between 8:30 a.m. and 1:30 p.m. Further record review revealed documentation of a Referral client summary dated indicating: "current location: North Port Behavioral. Reason for Seeking Supportive Housing and or care services: Was a resident at [Independent Living Community] - Eloped. Cannot go . Needs secured community. Health Needs: Primary Diagnosis Elopement. No interventions were put in place for elopement." Review of documentation of sheet from the transferring hospital revealed an admission date of with admitting diagnosis of major recurrent with psych symptoms. Reason for admission: danger to self, danger to others, . Discharge date	A 030		

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A 030	Continued From page 8 . Medication to be continued at discharge: , , 2 mg by every morning, indication/: changes. Discharged to Best Care Senior Living. On at 1:45 p.m., during an interview, Resident #1's Guardian said all of the (hospitalizations for self-injurious behavior) for Resident #1 were for eloping and being verbally and non-compliant with police and emergency medical technicians. When she was at "an independent living" she eloped several times, he would say at least 5 times. Resident #1's Guardian said since she was in an independent living, she eloped often and was well known by Sarasota County Sheriff's Office. They would call him and let him know what was going on. Sometimes the independent living would track her down as well. They were pretty good about it. Resident #1's Guardian said he was adamant when he spoke at length to the Administrator about the prior elopements and that those were his main concerns. He said the Administrator told him that it was a locked facility and it wouldn't be an issue. On at 1:36 p.m., during an interview, the Administrator said he has been in the role since , of this year and was the marketing director prior to taking the ED role. The Administrator said for new admissions to the facility himself, or the Resident Care Coordinator (RCC) would do an assessment to make sure new residents are appropriate and they are done to unless the person is hundreds of miles away. He said he did the assessment for Resident #1 on , while she was at the transferring hospital as she had walked away from the independent living where she lived. He said the independent community would not take her	A 030		

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and he assumed it was because she walked away from the facility. He said Resident #1's Guardian had told him Resident #1 had walked away from that facility, and he received the referral for Resident #1 from a private placement agency representative who called him and sent over the sheet regarding Resident #1, which indicated she could not go to the independent living due to walking away from there. The Administrator stated, "No interventions were put in place to prevent elopement as the building is a locked building and she would not be able to get out unless someone lets her out. No one told him she would go out the window." He said the officers told him at 4:00 p.m. on , Resident #1 was found in the wooded area behind the facility. He said after the officers left at 7:00 p.m., he checked the courtyard to make sure everything in the courtyard was locked up, and he left for the day. He said they started the day-1 preliminary adverse report and internal incident report, but they have not done anything else since that. He said he told the Maintenance Director to check all of the facility windows, but he has no documentation to show that it was completed. He said no training or anything like that for staff has been completed, and he did not follow up, making sure the Maintenance Director checked all the windows in the facility.

On at 2:05 p.m., during an interview, the Resident Care Coordinator (RCC) said she just took the position in of this year, was the Wellness Director (WD) prior to that, she said her duties entailed making sure the nursing department runs smoothly, meds are delivered, residents seen by physician, , , and follow ups for , , are made, schedule transport for , , .

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The RCC said the Administrator currently does -to- assessments for the residents before moving in and once done she gets the pre-assessment sheet, so she knows who is moving into the facility.
She said she did the in-house assessment for Resident #1 once she moved into the building, including reviewing the paperwork for the resident once admitted to the facility. The RCC said she received a stack of papers from the prior hospital for Resident #1, but she did not review the paperwork in detail. She said she reviewed the medication list and the Health Assessment Form 1823 and looked at some of the papers from the hospital but not the entire packet. She said she did not see the papers that indicated Resident #1 was an Elopement risk and was never told she had elopement tendencies.

2. On at 3:50 p.m., during a tour of the facility, the windows in are found to be unsecured, with no lock and able to open to a where a resident can step out through the window.

On at 9:25 a.m., during an interview, the Maintenance Director (MD) said himself and the Administrator only checked the window of after the incident but he did not do a tour of all of the rooms. The MD said that he put a bracket on the window in this morning so that it would be secure. He said that he wasn't sure he was supposed to, but he thought that the resident that is in there now could get out.

On at 10:55, during an interview, Caregiver Staff B said she has been working here almost 10 months, and she does not know who the elopement residents are.

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On at 10:56 a.m., during an interview, Med Tech Staff A she was not aware that Resident #1 had moved into the facility, no one told her anything about a new resident moving in, until she came from lunch on the day of the incident at 2:30 p.m., and heard the ED and the RCC saying that a resident had eloped from the facility, she said the facility ED called the police and notified them of the elopement but she is not sure of anything else as she left. Staff A said she has not received any training of any kind since the elopement occurred.

On at 4:50 p.m., during an interview, the Administrator said once he noticed the window was open outside, he went inside and checked the 3 residents that were on his list for elopement and made sure that the 3 windows that belonged to the elopement risk residents were secured. He then told the Maintenance Director (MD) to make sure that all of the windows in the facility were secure. The Administrator said he trusted the MD would take care of it, because he took the incident hard. The Administrator said there was no documentation of all of the windows being checked and secure. He said it was most important to him that the windows of the elopement risk residents he knew of were secure. He acknowledged residents in the facility and entering another room with unsecured windows could be a concern.

On at 8:45 a.m., during an interview, the MD said after the elopement, the only windows he was told by the Administrator to check were 107 and 109 to make sure they were secure because new residents were moving into the facility. The MD stated,"That is why I can't tell you exactly what rooms have secure windows and what

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A 030	Continued From page 12 rooms don't, no one has yet to tell me to secure any more of them. The Administrator didn't tell me anything." The facility had no documentation to indicate anything had been done currently to prevent reoccurrence of elopement. The facility failed to secure the window in as it is still easily opened, along with 2 additional windows in that are easily opened to where a resident can step through and not secured appropriately with locks, no documentation of any in-services post incident. The Administrator said that there was communication done with staff about the incident, but no education or in-services were conducted. No documentation provided. Class I .	A 030		
A 032 SS=J	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	A 032		

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(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
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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 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,

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A 032	Continued From page 14 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, observation and interviews, the facility failed to ensure each resident at risk for elopement is assessed appropriately and develop a plan, and ensure a safe environment, and maintain a general awareness of residents' whereabouts to prevent elopement for 1 (Resident #1) of 7 residents identified elopement risk. Failure to assess appropriately and develop a plan to prevent elopement behavior of Resident #1 lead to the resident eloping from the facility and subsequent . The facility failed to ensure residents deemed an elopement risk, have identification on their persons to include their name, the facility's name, address, and telephone number for 6 (Residents # 2, #3, #4, #5, #6, and #7) of 6 residents deemed an elopement risk. Failure to provide adequate supervision allowed residents to elope. The findings included: 1. Resident #1 was last seen at 8:30 a.m. by staff after breakfast on . Approximately around 1:30 p.m. while looking for the Maintenance Director, the Administrator noticed an open window on the 200 wing, on the	A 032		

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outside of the facility, with a bedspread along the ground and over the window. The Administrator and the Maintenance man went into the building and found the door of locked. Upon unlocking the door and entering, there was no sign of Resident #1. The facility began its elopement protocol and began to search the facility and the surrounding area. Resident #1 was able to open an unsecured window in and eloped from the facility, with staff unaware of the event.

Record review revealed Resident #1 was admitted to the facility on . Resident #1 eloped on sometime between 8:30 a.m. and 1:30 p.m.
Further record review revealed documentation of a Referral client summary dated indicating: "current location: North Port Behavioral. Reason for Seeking Supportive Housing and or care services: Was a resident at [Independent Living Community] - Eloped. Cannot go . Needs secured community. Health Needs: Primary Diagnosis Elopement. No interventions were put in place for elopement."

Review of documentation of sheet from the transferring hospital revealed an admission date of with admitting diagnosis of major recurrent with psych symptoms. Reason for admission: danger to self, danger to others, . Discharge date . Medication to be continued at discharge: 2 mg by every morning, indication/: changes. Discharged to Best Care Senior Living.

On at 1:36 p.m., during an interview, the Administrator said he has been in the role since of this year and was the marketing director

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prior to taking the ED role. The Administrator said for new admissions to the facility himself or the Resident Care Coordinator (RCC) would do an assessment to make sure new residents are appropriate and they are done to unless the person is hundreds of miles away.
He said he did the assessment for Resident #1 on , while she was at the transferring hospital as she had walked away from the independent living where she lived. He said the independent living community would not take her and he assumed it was because she walked away from the facility. He said Resident #1's Guardian had told him Resident #1 had walked away from that facility, and he received the referral for Resident #1 from a private placement agency representative who called him and sent over the sheet regarding Resident #1, which indicated she could not go to the independent living due to walking away from there. The Administrator stated, "No interventions were put in place to prevent elopement as the building is a locked building and she would not be able to get out unless someone lets her out. No one told him she would go out the window."
He said the officers told him at 4:00 p.m. on , Resident #1 was found in the wooded area behind the facility. He said after the officers left at 7:00 p.m., he checked the courtyard to make sure everything in the courtyard was locked up, and he left for the day. He said they started the day-1 preliminary adverse report and internal incident report, but they have not done anything else since that. He said he told the Maintenance Director to check all of the facility windows, but he has no documentation to show that it was completed. He said no training or anything like that for staff has been completed, and he has not followed up to make sure the Maintenance Director checked all

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A 032	Continued From page 17 the windows in the facility. On at 2:05 p.m., during an interview, the Resident Care Coordinator (RCC) said she just took the position in of this year, was the Wellness Director (WD) prior to that, she said her duties entailed making sure the nursing department runs smoothly, meds are delivered, residents seen by physician, and follow ups for are made, schedule transport for . The RCC said the Administrator currently does -to- assessments for the residents before moving in and once done she gets the pre-assessment sheet, so she knows who is moving into the facility. She said once she gets the medication list it is faxed to the pharmacy and once the resident is pre-registered through the computer software system for EMAR the pharmacy creates the EMAR, and she follows up to make sure the meds are ordered, delivered and onsite for staff to give the residents. She said she reviews the meds once delivered with the med list for accuracy and then the med are placed in the cart referenced to the hall they live on. She said she did the in house assessment for Resident #1 once she moved into the building, including reviewing the paperwork for the resident once admitted to the facility. The RCC said she received a stack of papers from the prior hospital for Resident #1, but she did not review the paperwork in detail. She said she reviewed the medication list and the Health Assessment Form 1823, and looked at some of the papers from the hospital but not the entire packet. She said she did not see the papers that indicated Resident #1 was an Elopement risk and was never told she had elopement tendencies.	A 032		

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On at 1:45 p.m., during an interview, Resident #1's Guardian said all of the (hospitalizations for self-injurious behavior) for Resident #1 were for eloping and being verbally and non-compliant with police and emergency medical technicians. When she was at "an independent living" she eloped several times, he would say at least 5 times. Resident #1's Guardian said since she was in an independent living, she eloped often and was well known by Sarasota County Sheriff's Office. They would call him and let him know what was going on. Sometimes the independent living would track her down as well. They were pretty good about it. Resident #1's Guardian said he was adamant when he spoke at length to the Administrator about the prior elopements and that those were his main concerns. He said the Administrator told him that it was a locked facility and it wouldn't be an issue.

2. On at 3:50 p.m., during a tour of the facility, the windows in are found to be unsecured, and able to open where a resident can step out through the window.

On at 9:25 a.m., during an interview, the Maintenance Director (MD) said the only time he checked all of the windows in the facility was with the surveyor on . The MD said himself and the Administrator only checked the window of after the incident but he did not do a tour of all of the rooms until he went with the surveyor on . The MD said that he put a bracket on the window in this morning so that it would be secure. He said that he wasn't sure he was supposed to, but he thought that the

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A 032	Continued From page 19 resident that is in there now could get out. 3. On at 12:25 p.m., Resident #2 was observed not wearing any identification on his person that included their name, the facility name, address and telephone number. On at 11:05 a.m., Resident #4 was observed sitting in the dining room. She had no identification on her. No bracelet or anklet of any kind with any form of identification present, with name, facility name, address and phone number. On at 11:07 a.m., Resident #3 was seated in . No identification was observed on her person. On at 11:10 a.m., Resident #5 was seated outside in the screened porch. When interviewed he said that no one has ever given him any identification and he doesn't have a wallet. He was not observed to have any identification on his person to include his name, the facility name, address and telephone number. On at 11:13 a.m., Resident #7 was observed sitting in the dining room. She was not observed to have any identification on her person. On at 1:25 p.m., Resident #6, an elopement risk resident, was observed sitting on the screened patio on the outside the 200 hallway. He was observed not to have any identification on his person with his name, the facility name, address, telephone number. On at 10:55, during an interview, Caregiver Staff B said she has been working here almost 10 months, and she does not know who the	A 032		

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elopement residents are, and she had never seen or put on any identification bracelets on any residents.

On at 10:56 a.m., during an interview, Med Tech Staff A she was not aware that Resident #1 had moved into the facility, no one told her anything about a new resident moving in, until she came from lunch on the day of the incident at 2:30 p.m., and heard the ED and the RCC saying that a resident had eloped from the facility, she said the facility ED called the police and notified them of the elopement but she is not sure of anything else as she left. Staff A said she has not received any training of any kind since the elopement occurred. She said there is a list of residents in the facility that are considered elopement risk, and they do not wear any ID on their person that include their name, the facility name, address and telephone number.

The facility had no documentation to indicate anything had been done currently to prevent reoccurrence of elopement.
The facility failed to secure the window in as it is still easily opened to a a resident can step through with no lock, along with 2 additional windows in that are easily open and not secured appropriately, no documentation of any in-services post incident.
The Administrator said that there was communication done with staff about the incident, but no education or in-services were conducted.
No documentation provided.

On at 9:25 a.m., during an interview, the Maintenance Director (MD) said the only time he checked any of the windows in the facility was with the surveyor on . The MD said himself and the Administrator only checked the window of

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A 032	Continued From page 21 after the incident but he did not do a tour of all of the rooms until he went with the surveyor on . The MD said that he put a bracket on the window in this morning so that it would be secure. He said that he wasn't sure he was supposed to, but he thought that the resident that is in there now could get out. On at 10:10 a.m., during an interview, the RCC said she knows there is a need to know general whereabouts of the residents in the facility. She said she aware of the regulation to have identification on the residents that re deemed an elopement risk. The RCC said she has the bracelets in her office, but they always take them off, so they haven't been on for a while. The RCC said the staff are unaware of the elopement process for the elopement risk residents and identification on their person. The RCC confirmed Resident #2, #3, #4, #5, #6, #7 had no identification on them to include their names, the facility name, address and telephone number. Class I .	A 032		
A 056 SS=G	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal	A 056		

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drug containers, then the following information must be recorded on each individual container:
1. The resident's name; and,
2. The identification of each medicinal drug in the container.
(b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another.
(c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.
(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly

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documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.

This Statute or Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure medications for residents who receive assistance with

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self-administration of medications are filled/ refilled in a timely manner for 2 (Resident #1, #8) of 6 residents reviewed for assistance with medication administration. Failure to do ensure medications are filled /refilled in a timely manner to have onsite to be given as ordered by the physician can cause, emotional, physical, mental, and or behavioral distress for residents who need daily, life sustaining medications.

The findings included:

1. Record review for Resident #1 revealed an admission date of .
Further review revealed Resident Health Assessment Form (1823) dated indicating Resident #1 required assistance with self-administration of medications. Further review revealed a medication order for , , 2mg (, for changes) documented on Resident #1's medication list.

Review of facility records showed on , Resident #1 eloped from the facility, and subsequently was found on in a forested area behind the facility

Record review found no evidence of documentation of an Medication Administration Record (MAR) for the month of to indicate any medications being administered as ordered by the physician to Resident #1 between and .

On at 12:00 p.m. during an interview 360 Care Pharmacist said the normal process with the facility is the pharmacy is given the medication orders prior to the residents' arrival. He said that Best Care is going through a transition and something may have

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between the cracks. According to his notes, the pharmacy was not contacted to provide any medications for Resident #1 until , and processed the order the same day. The Pharmacist said he is not sure what happened here. But in his notes, there is nothing prior to the for Resident #1.

On at 2:05 p.m., during an interview, the Resident Care Coordinator (RCC) said that she thinks she sent the paperwork to the pharmacy but is not sure when she sent it, she said when the meds did not arrive, she called the pharmacy on and was told they were working on it, after, she left and went home for the weekend as she does not work on Saturdays or Sundays. She said she came in on Monday and there were no meds for Resident #1 she called the pharmacy and was told there was an issue with the insurance and they were looking into. She said she did not call to speak with any staff over the weekend to see if any meds arrived for Resident #1, and the pharmacy does not open on weekends. She confirmed she did not call the physician or try to get any stat meds for Resident #1. The RCC acknowledged Resident #1 did not receive any medications as ordered by the physician for the entire time she was at the facility from through . The RCC said not getting her meds for the 5 days while at the building, especially the , , for changes, could have probably played a part in her behavior in eloping from the facility.

On at 2:48 p.m., during an interview, the facility third party pharmacist said they have 2 after hours systems that all facilities can choose from. The first is a phone number that is monitored 24 hours a day, 7 days a week (24/7). He said that you can leave a message and the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CARE SENOR LIVING AT SARASOTA LL	4450 8TH STREET SARASOTA, FL 34232

(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 056	Continued From page 26 service will get to you. The pharmacist said the other option is a text and a group chat that all facilities are part of. Staff can text or hop on the chat and these are also monitored 24/7. Facilities can ask a question or make a request anytime. The normal turnaround time is same day unless the request is made at night and then they would send medications by courier first thing in the morning. The pharmacist said they have pharmacists on call 24 /7 to provide support. 2. Record review of Resident #8's MAR revealed that Refresh Plus Drop (, relief) was not available from to , , 100 mcg (, , ,) has not been available since to be given as ordered by the physician. On at 10:10 a.m., during an interview, the Resident Care Coordinator (RCC) said normally the staff will let her know if the medication is getting low or put the empty package in her mailbox. She said she has not audited any of the Medication Administration Records and needs to incorporate it into her routine. The RCC said it definitely was an issue for Resident #8 when the meds are not filled/refilled time to be given to him as ordered by the physician, she was not sure what happened but will have to look into it.. She said that Resident #8 doesn't ordinarily refuse anything, so it can't be an exception or mistake. Class II .	A 056		