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
	AL11968685	A. BUILDING: _____ B. WING _____	08/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARASOTA ASSISTED LIVING LLC	3251 PROCTOR RD SARASOTA, FL 34231

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A 000	Initial Comments A complaint investigation for #2026013642, #2026013753 and generator monitoring visit survey was conducted at Sarasota Assisted Living LLC on [redacted]. Deficiencies were identified at the time of the survey.	A 000		
A 030 SS=D	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 1	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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A 030	Continued From page 2 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	A 030		

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A 030	Continued From page 3	A 030		

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 4 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. (l) 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	A 030		

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A 030	Continued From page 5 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 interview, the facility failed to provide a safe living environment free from for 3 (Residents #1, #2, #3) out of 3 residents reviewed. The facility failed to follow it's Resident Rights neglect and , policy and procedure.	A 030		

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A 030	Continued From page 6 Findings included: Requested and obtain the following policy: Policy titled: Resident , Neglect, , . Under "Procedure: . . . a. Reporting of neglect and/or , is MANDATORY. . . b. Staff immediately contact their supervisor if there is ANY suspicion of , neglect or , . . . Policy Criteria: It is everyone's responsibility to report any suspected or actual event of , neglect or . , neglect or , must be reported immediately regardless of time or day. , neglect or , events must be reported to the Executive Director, Director of Nursing, or Immediate Supervisor as soon as the event occurs. . ." Record review showed Resident #1 was admitted to the facility on . Health Assessment (HA) Form 1823 review for Resident #1, completed on , listed diagnosis including , ( ), type II , (, ,), and . Resident #2 was admitted to the facility on . HA Form 1823, completed on , included the following diagnosis: , , type 2 , and , , , . Resident #3 was admitted on //24. HA Form 1823, completed on , included the following diagnose: , , , ,	A 030		

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A 030	Continued From page 7 , , , valve , unspecified protein calorie , and , , . Surveillance video camera review that took place on at 11:04 a.m. showed that on at 16:35 p.m. Staff A after assisted Resident #3 to park his wheelchair at the dining room table, walked away and taps the of Resident#3's . Staff E was present at the time of the incident and did not react. On at 16:40 p.m. Resident #1 was sitting in his wheelchair in the dining room by the table. Resident #1 took his glass that was full of water and threw at Staff A. Staff A hit Resident #1 on the of the . Staff E was present and did not react. Staff E was observed coming with paper towels to clean the floor. Resident #1 started kicking Staff A and Staff A kicked Resident #1 once on his . Staff E was present did not react. On at 16:53 p.m. Staff A tapped Resident 3's of the . Staff D was present and did not react. On at 17:20 p.m. Staff B saw Resident #2 blowing his during medication assistance and she hit Resident #2 on the . On at 16:24 p.m. Staff A was observed tapping Resident#1's of the and then she came and swiped a plastic butter knife in front of Resident#1. Staff C was present during the incident and did not react. During an interview with the facility's Administrator on at 12:04 p.m. she said she was made aware of the issue when Resident #1's guardian notified her the end of the business day on . The Administrator said that Resident #1's guardian told her that during an earlier visit on she saw Staff A tapping Resident #3's of the in the presence of Staff D.	A 030		

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A 030	Continued From page 8 Resident #1's guardian told her none of the staff reacted even though they realized she saw them. The Administrator said she immediately suspended all staff involved including the ones that were present and did not report the incidents to her. The Administrator said she immediately began investigation and looked at footage from additional days and that is how she discovered the incident that took place on . The Administrator said she immediately notified the police. The Administrator said she immediately notified the Department of Children and Families (DCF) and the AGENCY. All 5 staff were terminated on . The Administrator said that none of the staff involved had prior history of not providing proper care to residents or accusation of maltreatment. All were employees with good work ethic, reliable and with no prior incidents on record. Class III .	A 030		