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
	AL11967960	A. BUILDING: _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIBISCUS PALACE WELLINGTON LLC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

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CZ816 SS=C	408.809(2)(a-c); 59A-35.090(2)(d)-(3) Background Screening-Compliance Attestation 408.809 (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ... to the Federal Bureau of Investigation for a national criminal history record check unless the person's ... are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ... of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ... electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ... to the Federal Bureau of Investigation for a national criminal history record check. The ... shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ... Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, the agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within	CZ816		

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CZ816	Continued From page 1 the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with [redacted], the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 59A-35.090(2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, [redacted], herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if [redacted] for any	CZ816		

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CZ816	Continued From page 2 disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to . , , . . . to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff signed and dated a Asstestation of Compliance at the time of there Agency for Healthcare Administration Level II background screening, for the 1 of 3 sampled staff (Administrator).	CZ816		

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CZ816	Continued From page 3 The Findings Included: On [redacted] at 12:30 PM, the Administrators file was reviewed and revealed the Administrators hire date was [redacted] and Level II Background screening was completed on [redacted]. There was no signed Attestation of Complaince that documented proof of disqualifying offenses and no break in service from a position that required a Level II background screening, for more than 90 days. At this time the Administrator was provided an opportunity to locate the documentation. On [redacted] at 3:00 PM, the findings were discussed with the Adminiustratir and she acknowledged the findings. Unclassified	CZ816		

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A 000	Initial Comments An unannounced Change of Ownership (CHOW) survey was conducted on . . . . . at Hibiscus Palace Wellington LLC. The facility had deficiencies identified at the time of the survey.	A 000		
A 010 SS=D	429.26(..&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (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 shall be based upon an assessment of the strengths, needs, and preferences of the resident, 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. 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 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. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A , ill resident who no longer meets the criteria for continued residency may remain in	A 010		

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A 010	Continued From page 1 the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 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 provider 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 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. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed 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 provider, 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 provider, the resident must be discharged from	A 010		

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A 010	Continued From page 2 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 a 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 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:	A 010		

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A 010	Continued From page 3 Based on a record review and interview, the facility failed to ensure that a resident Health Assessment form (AHCA 1823 form) was accurate and reflective of the resident's current diagnosis and care needs, for 1 out of 6 sampled residents' records reviewed (Resident #6). The findings included: Review of Resident #6's file revealed an admission date of . Review of Resident #1's AHCA 1823 Form dated ; documented the resident's diagnosis as , High ( ), , , Nephrolithiasis and the resident is on a regular diet. Review of Resident #1's Hospice Interdisciplinary Plan; revealed, Resident #6 is being treated for , date of Diagnosis noted as . Further review of record revealed Physician Orders, dated , documenting Resident #6 was prescribe an instant food and beverage thickener for diagnosis of . The facility failed to ensure that the AHCA 1823 form was not accurate and reflective of the resident's diagnosis and current care needs. The AHCA 1823 form did not include the diagnosis of and special diet prescribed (use of thickener). On at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee. Class III	A 010		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 4 59A-36.007 (8) 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 resident's representative. (b) Facility Resident Elopement Response	A 032		

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A 032	Continued From page 5 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 sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assess residents at risk for Elopement and failed to ensure the facility policy and procedures were followed before and after a resident Elopement, for 1 of 2 sampled residents (Resident#2). The findings include: On [redacted] a review of Florida Health Finders revealed the facility advertises Special Program and Services for Memory Care. Further review of the facility website also document [redacted]'s and [redacted] care services.	A 032		

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A 032	Continued From page 6 On . . . . . a review of the facility Elopement Policy and Procedure titled: A New Age of Senior Care ALF reads as follows. Elopement is defined as: when a resident leaves the facility without following the facility policy and procedure. II: The following procedure will be followed when determined by facility staff that a resident has eloped: a) Any staff member who is unable to locate a resident after checking the sign-in and sign-out log to verify the general whereabouts of the resident, must immediately notify the Administrator or Designee, irrespective of the time of day. b) If a resident is missing, all Assisted Living staff are notified and given a description of the resident and details of the last time and place the resident was seen Adam description of residents clothing. Photographs of the resident should be made available for identification. c) All staff members on duty during the period the resident was determined missing, shall search all interior and exterior sections of the house / building, and yard, d) If the resident is found inside or outside of the building (s), the staff discovering the resident must notify other staff members immediately. e) After the resident is found the direct care staff in charge, during the period of the residents return to the facility shall, conduct a thorough observation , evaluation/assessment and follow-up. If findings revealed that the resident	A 032		

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A 032	Continued From page 7 needs medical intervention. If so, the residents' physician shall be notified by staff on duty and orders shall be followed. f) If the missing resident is still not discovered during the search of the property, the administrator must be notified. The Administrator or Designee then assumes responsibility for the notification of outside agencies, such as the local police department, and Department of Children and Families (DCF). g) All staff members shall cooperate with the authorities involved with investigations and search for the missing resident. h) Family members or, in the absence of any family, other responsible persons will be notified by the Administrator or Designee after the search and within one hour of determining that the resident has eloped / is missing. i) Within one business day after preliminary investigation, of the eloped or missing resident incident , the Administrator will ensure the Agency for Healthcare Administrator (AHCA) is notified upon completion of the 1 Day Adverse Incident Report form by faxing the completed form to the Agency's Adverse Incident reporting office, as required 429.23 (3) F.S. in addition to faxing, the administrator shall also ensure that the report is sent via United States Mail. III. Reporting an Elopement as an Adverse Incident The ALF shall comply with Florida Statutes 429.23 (4), by providing a full report of the Adverse Incident on the residents' elopement / missing status within 15 days of the incident. This report shall include the results of the facility's	A 032		

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A 032	Continued From page 8 investigation into the adverse incident. Evaluation of Resident at Risk for Elopement a) Prior to resident's admission to the facility an ALF representative conducts a preadmission evaluation in order to determine whether the resident is appropriate for admission. This evaluation includes the resident's status regarding risk of elopement. b) If the interviews and reviews reveal that the resident is at risk for elopement and he/she is accepted for admission to the ALF, a current photo of the resident shall be maintained on his/her medical record. In the event that a resident, after admission determined to be at risk for elopement by facility staff, this information shall be documented in the resident record. In addition, the resident will have the following identification: a) Current photo in medical record b) Printed name, facility name, address and telephone number person. VI. Elopement Drills Effective . , per 429.41 (1) (a) F.S, in compliance with the required laws regarding elopement drills, this facility shall conduct two (2) drills per year in order to reduce / eliminate risk exposure to missing residents in order to protect the safety and wellbeing of the residents, subsequently preventing resident elopements. During the orientation of new hires and annual in-service training of all staff, the administrator or designee shall review the facility's resident elopement policy and procedure and have signed acknowledged that the employee received, reviewed, understand and shall comply with the	A 032		

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A 032	Continued From page 9 facility's elopement policy and procedure. Information for the following will be documented on the Elopement and Response Drill Form by the individual conducting the drill: * Resident Identification Information *Employee Involved * Search Actions (Location) * Individuals Notified * Result of Search * Residents status when found * Follow-up actions *Name & Title of Staff conducting drill VII. Documentation in Employee Record Per State Regulation the Administrator and Direct Care Staff must maintain on personnel record , documentation that they participate in the Facility /Resident Elopement Drill. On at approximately 9:15 AM, during an interview with Staff A, it was revealed Resident#2 eloped form the facility (not sure of date). Per Staff A, there were workers on the premises, and they left a secure gate open and the resident got out. Staff A stated the premises were searched, law enforcement were called, and a photo was provided. The resident was returned to the facility about 2 hours later (unsure of times). Staff A stated she has had Elopement Drill training upon hire, but she is not sure how often the facility conduct drills. During an interview with Staff D (Assistant Administrator), at 10;00 AM, she stated the residents are allowed to walk around on the outside and side yard areas of the facility. On she last saw Resident#2 at approximately 10:20 AM, she went to check on	A 032		

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HIBISCUS PALACE WELLINGTON LLC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

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A 032	Continued From page 10 Resident#2 at 10:30 AM and could not find her. She notified staff and proceeded to look for the resident inside the facility and outside in the immediate area. After she could not locate the resident, she notified the Administrator, called 911 (provided a picture of the resident), and notified the family the resident was missing. The resident was returned to the facility at approximately 12:00 PM by law enforcement. Staff D stated it was later discovered the code secure gate was left open by workers and the resident was able to leave through an unsecured gate at the of the property. Once discovered the gate behind the code secured fence where the resident eloped from, has been reinforced with a nailed board, and the staff ensure the code gate is closed securely after each entry or exit. On between 9:10 AM and 10:00 AM during the observational tour, 14 of 14 residents were observed and there was no facility identification visible on any of the residents. At this time, an interview was conducted with the Administrator, and she was asked if Resident#2 had any facility identification on her person at the time of her elopement, and the Administrator answered " No". The Administrator was also asked by this surveyor, being a Memory Care facility, does any of the residents identified as elopement risk have facility identification that included the residents' name, the facility name, address, and telephone number, on their person? The Administrator answered, she was not aware that the facility was advertised as a Memory Care facility, and none of the residents in the facility had any facility identification on their person. Further observation of the location of elopement revealed, a coded secure gate that lead to a wooden fence secured with a nailed board to prevent exit. There was place for a padlock, but	A 032		

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A 032	Continued From page 11 there was no , lock observed (photographic evidence obtained). On at 10:15 AM, during an interview with Resident#2's husband, he stated they called me when she escaped. She out when a contractor left the door open. They called the Sheriff's Department and had a Silver Alert. She was found at a strip mall down the way trying to get into the movies. She was gone two-hours. An Emergency Medical Services ( ) checked her out. All she had was a chipped . I'm taking her to the dentist. They handled it well, showed concern. ,I'm not sure what they did, but they said they beefed up security On at 11:00 AM, a review of Resident#2's Agency for Healthcare Administration Health Assessment (AHCA Form 1823) dated revealed, a medical history of , no physical or sensory limitations, but alert and oriented to family, the residents is documented as an elopement risk. The resident is independent with ambulation, eating, and transfer, and requires supervision with bathing , , grooming, and tilting. Resident requires daily overstep of elbowing, whereabouts, and daily task. At this time, the resident observation notes were reviewed and a late entry documenting the elopement, notification of law enforcement, family, and physician, was entered after a entry, this surveyor was unable to determine the date the entry was documented. Further review of the residents' medical record, there was no documentation notes or incident report that showed the facility followed the elopement policy and procedure and documented a thorough observation, evaluation/assessment and follow-up of the elopement, or that an	A 032		

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A 032	Continued From page 12 elopement had taken place. On . . . . . at approximately 1:00 PM, during a follow-up interview with the Administrator, she stated she was not at the facility and was notified by staff of the residents' elopement. She stated the resident was located by law enforcement at a local movie theater (approximately 0.4 miles away from the facility- walking time approximately 8 minutes), the resident was assessed by local . . and returned to the facility by . . at approximately 12:00 PM. According to the Administrator, there was no identification on the resident's person at the time of the elopement. The Administrator was also unable to provide a facility incident report that documented the details of the elopement. Further interview with the Administrator, revealed the exit fence has been secured, however, in accordance with the facility policy and procedure, there has been no 1 Day or 15 Day Adverse Incident Report submitted to AHCA, and there is no documentation except the late entry made in the progress notes. The facility has not at a minimum, made a daily effort to ensure that at risk residents have identification on their persons that includes their name, facility name, address, and telephone number. At this time, the Administrator was unable to provide any documentation of any elopement risk assessments conducted on Resident#2 as indicated in the facility policy and procedure. Upon Resident#2's return, the Administrator failed to conduct a thorough observation, evaluation/assessment and follow-up to ensure appropriate safety measures were put in place. On . . . . . at 1:30 PM, a review of the facility staff schedule for the date of , there were two (3) direct care staff scheduled, Staff A , Staff D, and Staff E, with a census of 14	A 032		

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A 032	Continued From page 13 residents. On . . . . . at approximately 12:40 PM, the Administrator, was asked for documentation of the facility's elopement drills. At this time Administrator provided an Elopement document dated . . . . . , that was labeled Missing Person Incident Report Form and appeared to document an actual Elopement, there were conflicting dates on the form. There was no sign in sheet or documentation of who was in attendance for the elopement drill. At this time, an interview was conducted with the Administrator and she stated, there was no sign-in sheet to verify an Elopement Drill was conducted for the facility before or after the Elopement. She also stated at this time, the residents do not have any facility identifiers on their person in case of an Elopement. On . . . . . at 1:47 PM, the Adverse Incident Repotting system was reviewed and revealed, no Adverse Report submitted involving Resident#2 on or around . On at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee. Class III	A 032		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing	A 054		

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A 054	Continued From page 14 pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review, interview, and observation, The facility failed to ensure the medication observation record was immediately updated each time the medication dosage is missed for 1 out of 4 sampled residents. (Resident #4) The findings include: Based on record review, interview, and observation, the facility failed to ensure the medication observation record was immediately	A 054		

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A 054	Continued From page 15 updated each time the medication dosage is missed for 1 out of 4 sampled residents (Resident #4). The findings include: On at approximately 12:00 PM, observations of Staff D, who is an unlicensed staff, medication passes were observed for Resident #4. Staff D stated the prescription order for , 50mg was reduced to , 25 mg. At this time, Staff D stated we do not have the new order from the Pharmacy and tablet will have to be broken in half Surveyor intervention prompted Staff D to check with Administrator, who is a Nurse; on how to proceed. At this time, the Administrator made the decision to wait on the Pharmacy to deliver the new order, scheduled for . Staff D signed off on the Medical Observation Record (MOR) for 12:00 PM dose. Staff D did not indicate the reason for the missed dosage on the of the MOR. (Photographic Evidence Attached). On at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee. Class III	A 054		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and,	A 152		

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A 152	Continued From page 16 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe, as it relates to being free of hazards and decent living environment. The findings include:	A 152		

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A 152	Continued From page 17 On . . . . . at approximately 9:36 AM, a tour of the secured facility was conducted. It was noted that, the inside deck panel had metal object that was partially there with sharp edges (Photographic Evidence). The broken panel has the potential to be a dangerous hazard if a resident touches the wall and hurts their . . . It was also noted that, Bedroom #6 has wall damage containing 6 quarter sized holes in the wall and paint peeling revealing the gray panel under the wall. (Photographic Evidence Attached). On at approximately 2:15 PM, a observation of the facility secure . . . yard area,where residents can walk unattended, revealed a large square container with a dept of approximately 3 ft. The container was observed empty with miscellaneous debris inside and several boards insecurely placed on the top. The container is in plain site and accessible to all residents. (Photographic evidence obtained). On at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee. Class III	A 152		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable	A 161		

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A 161	Continued From page 18 rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as	A 161		

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A 161	Continued From page 19 described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all staff had a completed employment application with references, for 1 of 3 sampled staff (Administrator). The Findings Included: On at 12:30 PM, the Administrators file was reviewed and revealed no completed employee Application with references on file. The Administrators hire date was . . . . . At this time, the Administrator was provided an opportunity to locate the documentation; no documentation was provided. On . . . . . at 3:00 PM, during an interview with the Administrator, she acknowledged the findings and provided no additional documentation for review. Class III	A 161		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race,	A 162		

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A 162	Continued From page 20 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance . . , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, ..., or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A ⌄ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌄ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or	A 162		

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A 162	Continued From page 21 administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable.	A 162		

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A 162	Continued From page 22 (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on resident record review and staff interview, the facility failed to maintain on the premises all physician orders and Hospice Nurse's notes, for 1 of 2 Hospice resident (Resident #5 and #6).	A 162		

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A 162	Continued From page 23 The findings include: On record reviews were conducted for Resident #6 medical files. Resident #6's AHCA Form 1823 dated , revealed Resident #6 is on Hospice for , , ( ), , , ( ), and , , (ST). Hospice Nurse's Notes could not be located within the resident's medical record. On at 2:25 PM, Resident #6 Hospice notes were requested from the Administrator. The Administrator stated the Hospice Nurse's Notes were not on the premises and confirmed she did not know about the progress of Resident #6 , , and ST. At this time, The Administrator contacted the Hospice nurse to request the missing documentation. The facility provided no additional information for review. On at approximately 9:15 AM, during an interview with Staff A, it was revealed, Resident#5 has a Cocxy , and is receiving Hospice Care. A review of the facility Hospice file revealed no documentation of onset date,no weekly care. notes, and there were no measurements ore progress on file. Further review of the Hospice physician narrative revealed, on the , was documented as a , no additional documentation was in the file. At this time, he Administrator was provided an opportunity to locate the documentation, she stated she had to request the documents from Hospice. On at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee.	A 162		

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A 162	Continued From page 24 Class III	A 162		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 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; 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	A 165		

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A 165	Continued From page 25 the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States 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, by electronic mail, facsimile, or United States 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 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	A 165		

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A 165	Continued From page 26 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. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to complete and submit the preliminary report (1 day report) and the full report (15 day report) to Agency for Healthcare Administration regarding an elopement for 1 out of 6 sampled resident records reviewed (Resident #2), in which local law enforcement was involved .	A 165		

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A 165	Continued From page 27 The findings included: On at approximately 9:15 AM, during an interview with Staff A, it was revealed Resident#2 eloped form the facility (not sure of date). Per Staff A, there were workers on the premises, and they left a secure gate open and the resident got out. Staff A stated the premises were searched, law enforcement were called, and a photo was provided. The resident was returned to the facility about 2 hours later (unsure of times). Staff A stated she has had Elopement Drill training upon hire, but she is not sure how often the facility conduct drills. During an interview with Staff D (Assistant Administrator) at 10;00 AM, she stated the residents are allowed to walk around on the outside and side yard areas of the facility. On , she last saw Resident#2 at approximately 10:20 AM, she went to check on Resident#2 at 10:30 AM and could not find her. She notified staff and proceeded to look for the resident inside the facility and outside in the immediate area. After she could not locate the resident, she notified the Administrator, called 911 (provided a picture of the resident), and notified the family the resident was missing. The resident was returned to the facility at approximately 12:00 PM by law enforcement. Staff D stated it was later discovered the code secure gate was left open by workers and the resident was able to leave through an unsecured gate at the of the property. Once discovered the gate behind the code secured fence where the resident eloped from, has been reinforced with a nailed board, and the staff ensure the code gate is closed securely after each entry or exit.	A 165		

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A 165	Continued From page 28 On [redacted] at 11:00 AM, a review of Resident#2's Agency for Healthcare Administration Health Assessment (AHCA Form 1823) dated [redacted] revealed, a medical history of [redacted], no physical or sensory limitations, [redacted] but alert and oriented to family, the residents is documented as an elopement risk. Resident requires daily overstep of elbowing, whereabouts, and daily task. At this time, the resident observation notes were reviewed and a late entry documenting the elopement, notification of law enforcement, family, and physician, was entered after a [redacted] entry, this surveyor was unable to determine the date the entry was documented. On [redacted] at approximately 1:00 PM, during a follow-up interview with the Administrator, she confirmed Resident #2 had eloped from the facility and law enforcement was involved in locating her. She further confirmed she had not completed and submitted the 1 day nor the 15 day report to the Agency for Healthcare Administration. On [redacted] at 1:47 PM, the Adverse Incident Reporting system was reviewed and revealed, no Adverse Report submitted involving Resident#2 on or around [redacted]. On [redacted] at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee. Class III	A 165		
A 181 SS=D	59A-36.019(2) FAC Emergency Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan	A 181		

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A 181	Continued From page 29 must be submitted for review and approval to the local emergency management agency. (a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of receiving notification that the plan must be revised. (b) A new facility as described in rule 59A-36.014, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license. (c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval. 1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities. (e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a Comprehensive Emergency Management Plan (CEMP) to the local Emergency Management Agency for review and	A 181		

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A 181	Continued From page 30 approval. The findings Include: On . . . . . at approximately 11:15AM, the facility approved CEMP was requested. The Administrator stated the facility has never received an approved CEMP. The Administrator provided a receipt for submitted CEMP revealing the plan was submitted while the survey was being conducted on . . . . . at 9:33AM. The facility provided no additional information for review at this time. On . . . . . at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee. Class III	A 181		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure . . . . . air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the	A 200		

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A 200	Continued From page 31 event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit	A 200		

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A 200	Continued From page 32 for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include	A 200		

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A 200	Continued From page 33 information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this	A 200		

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A 200	Continued From page 34 rule. Assisted living facility plans previously submitted and approved pursuant to emergency rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the	A 200		

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A 200	Continued From page 35 local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than [illegible], have implemented the plan required under this rule. (b) The Agency shall allow an extension up to [illegible] to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery	A 200		

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A 200	Continued From page 36	A 200		

for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite.
2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either:
a. Fully and safely evacuate its residents prior to the arrival of the event; or
b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility.
(d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license.
(e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction.
(f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule.
(5) POLICIES AND PROCEDURES.
(a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967960	A. BUILDING: _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIBISCUS PALACE WELLINGTON LLC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

(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 200	Continued From page 37 fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429,	A 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 200	Continued From page 38 part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a Emergency Power Plan (EPP)	A 200		

Agency for Health Care Administration

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A 200	Continued From page 39 to the local Emergency Management Agency for review and approval. The Findings Included: On at approximately 11:15AM, the facility approved EPP was requested. The Administrator stated the facility has never received an approved EPP. The facility provided no additional information for review at this time. During the exit conference on at approximately 3:15 PM, the findings were discussed and acknowledged by the Administrator and Designee. Class III	A 200		