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
	AL11966792	A. BUILDING: _____ B. WING _____	R 11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE AMOR ALF INC	10930 S W 143 COURT CROSSINGS, FL 33186

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CZ824 SS=C	408.811 FS; 59A-35.120 FAC Right of Inspection; Inspection Reports 408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.- (1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application. (a) All inspections shall be unannounced, except as specified in s. 408.806. (b) Inspections for relicensure shall be conducted biennially unless otherwise specified by authorizing statutes or applicable rules. (2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification. (3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an	CZ824		

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CZ824	Continued From page 1 offsite review. (4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency. (5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required. (6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership. (b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection. 59A-35.120 Inspections. (1) When regulatory violations are identified by the Agency: (a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency	CZ824		

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CZ824	Continued From page 2 notice to the provider, unless an alternative timeframe is required or approved by the Agency. (b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time. (2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency. (3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide: (a) Documentation from the accrediting agency including the name of the accrediting agency, the beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation. (b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to correct deficiencies within 30 days once they were identified by the Agency for Health Care Administration. Findings:	CZ824		

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CZ824	Continued From page 3 A review of records and interviews conducted on . . . . . showed that the facility had deficiencies in medication records, medication storage and disposal, Staffing standard levels, Straining staff in-services, physical plant safe living environment, and emergency environmental control. Interviews and record reviews on showed that the facility had not corrected those deficiencies within the timeline.	CZ824		

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{A 000}	Initial Comments A follow-up survey was conducted at Casa De Amor ALF Inc on . . . . . Deficiencies were identified at the time of the survey.	{A 000}		
A 007 SS=D	429.26(11) FS; 58A-5.0181(1) FAC Admissions - Criteria 429.26 (11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part of chapter 400, shall be retained in a facility licensed under this part. 58A-5.0181 (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication.	A 007		

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A 007	Continued From page 1 a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility exploys a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden. 10. Not have any , or 4 , . A resident requiring care of a may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care provider; b. The condition is documented in the resident's record and admission and discharge logs; and,	A 007		

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A 007	Continued From page 2 c. If the resident's condition fails to improve within 30 days as documented by a health care provider, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. . . . . airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with . . . . . , c. Monitoring of gases, d. Management of post-surgical drainage tubes and vacuum devices; e. The administration of . . . . products in the facility; or f. Treatment of surgical . . . . . or . . . . . , unless the surgical . . . or and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. . . . . and . . . . . performed in the facility; b. . . . . performed in the facility. 13. Not require 24-hour nursing supervision. 14. Not require skilled rehabilitative services as described in rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual;	A 007		

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A 007	Continued From page 3 b. The medical examination report required by section 429.26, F.S., and subsection (2) of this rule, if available; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable ,, or assistance with routine , care of site , placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from , with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) An individual enrolled in and receiving hospice services may be admitted to an assisted living facility as long as the individual otherwise meets resident admission criteria.	A 007		

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A 007	Continued From page 4 (e) Resident admission criteria for facilities holding an extended congregate care license are described in rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that two out of ten sampled residents met the admission criteria (#9 and #10). Findings included: On at 7:13 AM, Staff B stated that there were two residents (#9 and #10) at the hospital; one (#9) of the two hospitalized residents became aggressive and transferred to the hospital and the other resident (#10) had a problem with one of his , a , . Both residents were new in the facility. On at 12:04 PM, the Administrator stated that stated that Resident #9 became aggressive and attempted to hit staff because he wanted to go out on the street. A review of Resident #9's record showed that there were discharge papers from a local hospital on prior to the admission to the facility. The resident was at the hospital from to under a from the previous facility. The reason for admission to the hospital was because he was aggressive, , agitated, not sleeping and attempted to hit the staff. The hospital discharge diagnosis was , . A review of the facility's license showed no specialty license for Limited mental Heath, a designation required if a facility served one or	A 007		

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A 007	Continued From page 5 more persons with mental health conditions. A review of Resident #9's hospital record showed that the facility sent the resident to a local hospital on . . . . . The ambulance sheet showed that the resident was picked up on at the facility. The resident had aggressive behavior , for 3 hours. The staff from the facility claimed to the ambulance personnel that the resident was aggressive and violent and became more aggressive when the staff attempted to get closer. The resident arrived to the hospital on . . . . at 4:55 PM with complaints of AMS ( ) and aggression. He was agitated, ... , combativeness, and . He had to . . . . . arms and . . . . presented to . . . The hospital transferred the resident to , ... unit on . . . . . with the diagnosis of unspecified , not due to a substance or known physiological condition. The reason for transferring was that the resident was extremely and severely agitated and aggressive behavior, very poor touch with reality. One of the doctor notes showed that the resident was "clearly a potential danger to others." On :06 PM, the Administrator stated that Resident #10 complained of , . in one of the . A review of Resident #10's record showed that his admission to the facility was on . . . . . The facility did not document that he used a , at the time of admission or that anyone checked his skin under the , . There were some hospital discharge papers in the . . . of the record showing that the resident had an ankle after he suffered a . , . . , . and collapsed on .	A 007		

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A 007	Continued From page 6 A review of progress notes in Resident #10's record showed it had the name of the resident covered with whiteout. The facility completed a note on showing that the resident was sent to the hospital due to , in the at night. On at 1:04 PM, the Administrator stated that the resident had a covered with a at the time of admission to the facility. That area could not get wet and the resident needed to rest. Review of Resident #10's hospital record showed that he arrived on at 8:50 PM with the chief complaint of sustaining a right ankle on and after removing the bandage on had and redness on the ankle. The resident was hospitalized from to . The hospital course showed that the resident had history of ( ), and was legally . The Assisted Living Facility (ALF) sent him to the emergency room because he had in the skin of the right ankle. The resident on at his previous ALF and had an ankle . The hospital placed a to the resident's ankle and on that new ALF's staff noticed that there was coming out close to the , . The staff removed the , and noticed that there were in that area which contained . The assessment completed at the hospital on showed that he had to the right lower extremity with at least two (2) large that contained most likely . He received two different during his stay at the hospital because he had bacteremia upon	A 007		

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A 007	Continued From page 7 admission. The resident informed the hospital having and chills and removed the , . The resident had an orthopedic surgery for fixing his right ankle on . The discharged diagnoses from the hospital on for the resident included: closed right trimalleolar , ankle , Acute , Injury (AKI) on , ( ), and bacteremia due to . Hospital record showed under the teaching section that Bacteremia was the presence of in . The entered the bloodstream and could cause a life-threatening reaction called , . Bacteremia could spread to other parts of the body including the , joints, and . The reasons for the getting into the included skin , cut on the skin or having a long-lasting ( ) and elderly adults were at higher risks. Class III	A 007		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.	A 025		

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A 025	Continued From page 8 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated written record reflecting significant changes or any illness that resulted in medical attention for two out of ten sampled residents (#9 and #10).	A 025		

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A 025	Continued From page 9 Findings included: Review of Resident #9's record showed that his admission date to the facility was on . There was a resident progress notes completed on showing that the facility called an ambulance and sent him to a local hospital because he did not feel well. Review of Resident #9's record showed that there were discharge papers from a local hospital on prior to the admission to the facility. The resident was at the hospital from to because he was from the previous facility. The reason for admission to the hospital was because he was aggressive, , agitated, not sleeping and attempted to hit the staff, an a injury. The hospital discharge diagnosis was . The resident had a follow up with the psychiatrist on at 9 AM. There was no evidence that the resident went to the with the psychiatrist. The resident's ambulance record showed that the ambulance picked up the resident on at the facility. The resident had aggressive behavior for 3 hours and . A review of Resident #10's record revealed that a local hospital admitted the resident due to " ", Ankle injury/ , and "Acute Injury" on . The hospital performed surgery on the resident's right . The hospital discharged the resident the same day to another ALF. A review of Resident #10's record showed that the facility admitted the resident on with no diagnosis information and with a "Health	A 025		

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A 025	Continued From page 10 Assessment" done since . . . . On , record review showed that the facility sent the resident to hospital due to , . on one of his . On , a review of hospital records revealed that patient was admitted to the hospital due to a "Right ". The facility had no record on how the resident received care for his since his admission date. Uncorrected Class III	A 025		
A 027 SS=D	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , ... and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , ... health care provider. This Statute or Rule is not met as evidenced by: Based on record A review and interview, the facility failed to assist and remind resident about scheduled . , , ... for two out of ten	A 027		

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	AL11966792	A. BUILDING: _____ B. WING _____	R 11/08/2019

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CASA DE AMOR ALF INC	10930 S W 143 COURT CROSSINGS, FL 33186

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A 027	Continued From page 11 sampled residents (#9 and #10). Findings included: A review of Resident #9's record showed that there were discharge papers from a local hospital on . . . . . prior to the admission to the facility. The resident was at the hospital from to . . . . . because he was . . . . . from the previous facility. The reason for admission to the hospital was because he was aggressive, . . . , agitated, not sleeping and attempted to hit the staff. The hospital discharge diagnosis was , . The resident had a follow up , , . . . with the psychiatrist on . . . at 9 AM. There was no evidence that the resident went to the , , ... with the psychiatrist. A review of Resident #9's hospital record showed that the facility sent the resident to a local hospital on . . . . . The ambulance sheet showed that the resident was picked up on at the facility. The resident had aggressive behavior for 3 hours and , ... The staff from the facility claimed to the ambulance personnel that the resident was aggressive and violent and became more aggressive when the staff attempted to get closer. The resident arrived to the hospital on . . . at 4:55 PM with complaints of AMS ( ) and aggression. He was agitated, ... , combativeness, and . He had to . . . . arms and . . . presented to . . . The hospital transferred the resident to , ... unit on . . . . . with the diagnosis of unspecified , not due to a substance or known physiological condition. The reason for transferring was that the resident was extremely and severely agitated and aggressive behavior, very poor touch with reality. One of the	A 027		

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A 027	Continued From page 12 doctor notes showed that the resident was "clearly a potential danger to others." A review of Resident #10's record showed that his admission to the facility was on . . . . . There were some hospital discharge papers in the of the record showing that the resident had an ankle after he suffered a , and collapsed on . . . . . The hospital recommended to follow up with an orthopedic within one to two days from the discharged on . There was no evidence in the resident's record of seeing an orthopedic. According to the resident progress notes in Resident #10's record the facility sent the resident to the hospital at night on . . . . because he had , on the . A review of Resident #10's hospital record showed that he arrived on . . . . . at 8:50 PM with the chief complaint of sustaining a right ankle . . . . on . . . . . and after removing the bandage on had . . , . . . and redness on the ankle. He received two different , during his stay at the hospital because he had bacteremia upon admission. The resident informed the hospital having . . and chills and removed the , . The resident had an orthopedic surgery for fixing his right ankle . . . . on . . . . . The discharged diagnoses from the hospital on . . . . . for the resident included: closed right trimalleolar , ankle , Acute , Injury (AKI) on . . . . . , - . . . . . (. .), and bacteremia due to . . . . . On at 1:04 PM, the Administrator stated that at the time of admission to the facility, the resident had a covered with a . She	A 027		

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A 027	Continued From page 13 said that the [redacted] could not get wet, and that the resident he needed to rest. The social worker made the [redacted] with the orthopedic as instructed at the discharge. The owner did not document any of the information. She stated she did not know if the resident did the follow up in the previous facility. Class III	A 027		
{A 030} SS=D	58A-5.0182(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 58A-5.0182 (6) 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 58A-5.0181, 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; [redacted] Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free	{A 030}		

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{A 030}	Continued From page 14	{A 030}		

telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The 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 58A-5.0181, 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 universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(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 15 must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 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.	{A 030}		

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{A 030}	Continued From page 16 (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 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	{A 030}		

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{A 030}	Continued From page 17 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 shall be set forth in writing. 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	{A 030}		

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{A 030}	Continued From page 18 retaliatory action cannot be taken against a 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(1)(a), FS 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 observation and interview, the facility failed to ensure that residents were treated with respect due to recognition of personal dignity for two out of ten sampled residents (#2 and #3). Findings included:	{A 030}		

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{A 030}	Continued From page 19 On at 8:01 AM, the Med Pass Tech from hospice started assisting Resident #3 with self-administration of medication in # . Residents #2 and #3 rested on their beds in # . There was privacy between Residents #2 and #3's beds. On at 8:02 AM, there were two windows in # over Residents #2 and #3's beds and they had open blinds. There was a Certified Nursing Assistant (CNA) from hospice providing a bed bath to Resident #2. Resident #2 had the sleep gown over her , leaving exposed the brief. At 8:03 AM, the CNA removed all clothes from Resident #2. Resident #2 was naked and with no privacy from Resident #3, the Med Pass Tech and the exterior from the opened windows. On at 8:14 AM, the CNA from hospice continued giving bath care to Resident #2 without providing any privacy. On at 8:48 AM, the CNA from hospice uncovered Resident #3's body parts (whole body) from her clothes and leaving her naked. There was no privacy in place between Residents #2 and #3 or from the Med Pass Tech. On at 9:05 AM, the CNA from hospice stated that she forgot to close the blinds before starting the bed bath with Resident #2. The facility did not have any way of providing privacy to the residents during baths. Uncorrected Class III	{A 030}		

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A 031	Continued From page 20	A 031		
A 031 SS=D	58A-5.0182(7) FAC 429.255(1)(b). FS Resident Care - Third Party Services 58A-5.0182 (7) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were	A 031		

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A 031	Continued From page 21 unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. 429.255(1)(b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s physician. However, the owner or administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the facility. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the arranged third party services meet the residents' needs for two out of 10 (#6, #2 and #3) sampled residents. Findings included: On at 7:42 AM, the Med Pass Tech (MPT) from hospice arrived and stated that she gave medication to Residents #2, #3, and #6. She was a CNA (Certified Nursing Assistant). On at 7:49 AM, the MPT from hospice assisted Resident #6 with self-administration of medication. She did not read aloud or informed the resident with the name of the medications given. On at 8:15 AM, the MPT from hospice assisted Resident #3 with self-administration of medication. She did not read aloud or informed the resident with the name of all medications given. The MPT used a pill crusher for crushing Resident #3's medications and did not sanitize it	A 031		

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A 031	Continued From page 22 between medications. On further observation at 8:25 AM, the MPT dispensed 15 ml of to the clear disposable cup that Resident #3 took after. A review of Resident #3's Medication Observation Record showed that there was an order for taking 30 ml twice a day of 10 GM/ 15 ML. Reconciliation of Resident #3's Medication showed that there was a bottle with a label showing to take 30 ml twice a day of 10 GM/ 15 ML. On at 9:04 AM, the MPT from hospice stated that she read the wrong part of the order for Resident #3's . On at 8:49 AM, observed the MPT from hospice take out a tablet of , from the medication card, crushed it and mixed it with applesauce. The MPT put the mixed of the crushed medication with the applesauce in a spoon and placed it inside Resident #2's . A review of progress notes of Resident #2's record showed that Resident #2 needed assistance with self-administration of medication according to the health assessment completed on . Class III	A 031		
{A 054} SS=D	58A-5.0185(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;	{A 054}		

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{A 054}	Continued From page 23 or a medication listing with the prescription number, the name and address of the issuing 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 observation, record review and interview, the facility failed to document any known [illegible] that a resident had in the Medication Observation Records (MORs) for one out of ten (#3) sampled residents. The facility failed to ensure that the medications had a scheduled time for four out of ten sampled residents (#3, #2, #6, and #10). Findings included:	{A 054}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966792	A. BUILDING: _____ B. WING _____	R 11/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE AMOR ALF INC	10930 S W 143 COURT CROSSINGS, FL 33186

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{A 054}	Continued From page 24 On at 7:39 AM, there was a binder with sheets inside. The sheets were Medication Observation Records for Residents #2, #3, #6, #9 and #10. Review of Resident #3's MORs showed that the box for identifying the resident's was blank. There was an order for applying 2% to the affected area daily as needed. The order started on and it was signed as given from thru , on , on and from thru . There was no documentation indicating the time or reason for the resident to receive the medication. There was an order for applying 20% to the affected area daily as needed starting on . The resident received the twice a day at "AM" and "PM" from to and there was no documentation indicating the time or reason for the resident to receive the medication. The resident's medications did not have a scheduled time; they just showed "AM" and "PM". Review of Resident #3's record showed that the facility identified in the demographic sheet. Review of Resident #2's MORs showed that the box for identifying the resident's was blank. There was an order for taking one tablet by twice a day of 500 mg. The did not have a scheduled time; it just showed "AM" and "PM". Review of Resident #6's MORs showed that the medications did not have a scheduled time; they just showed "AM" and "PM".	{A 054}		

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{A 054}	Continued From page 25 Review of Resident #10's MORs showed it included seven medication and none of them had a scheduled time; they just showed "AM" and "PM". The MOR did not show the route that the resident would receive the seven medications. The boxes for identifying the resident's [illegible], the resident's health care provider telephone number and the charting period for receiving medications were blank. On [illegible] at 12:42 PM, the Administrator stated that the MORs for Residents #2, #3, and #6 came from the hospice pharmacy. On further interview at approximately 1:45 PM, the Administrator stated that she would fix the problems found on the MORs. Uncorrected Class III	{A 054}		
{A 055} SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication;	{A 055}		

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{A 055}	Continued From page 26 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 58A-5.0181, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident	{A 055}		

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{A 055}	Continued From page 27	{A 055}		

or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.
(e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f).
(f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation and interview the facility failed to keep centrally stored medications locked and out of reach of residents at all times.

Findings included:

On at 7:07 AM observation during the tour in the facility revealed unlocked labeled

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{A 055}	Continued From page 28 medications in one of the closets located next to # . The refrigerator inside the kitchen area was unlocked. There was an unlocked box inside the refrigerator that had labeled medications. The refrigerator door had different medications stored on 2 of the 3 shelves and inside the small compartment. The refrigerator stayed unlocked during the time of the survey and was frequently used by the staff. On _____ at 01:45 PM, Staff A acknowledged the deficiency. She stated that she stored the medications inside the refrigerator because the medications needed to stay refrigerated. Class III	{A 055}		
A 056 SS=D	58A-5.0185(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 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	A 056		

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A 056	Continued From page 29 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 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	A 056		

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A 056	Continued From page 30 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, interview and record review, the facility failed to ensure that medications were properly labeled for one out of ten sampled residents (#6). The facility failed to ensure that residents received medications as ordered by the Primary Care Physician (PCP) for one out if ten sampled residents (#6). Findings included: On at 7:33 AM, there was a medication bin with Resident #6's name. There was a tube of	A 056		

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A 056	Continued From page 31 . . . . . in the bin and it missed the label. On . . . . . at 12:28 PM, the Administrator revealed that the unlabeled cream belonged to Resident #6. Review of Resident #6's Medication Observation Record (MOR) showed that there was an order for applying . . . . . cream to the affected area daily for 15 days starting . . . . . . The medication showed signed on the MOR from thru . On at 12:39 PM, the Administrator stated that Staff B informed her that Resident #6's hospice nurse applied the cream to him. The application of the cream can happened in the morning, noon or afternoon. There was no specific hour. She did not know about missing dates of administration. Class III	A 056		
A 058 SS=D	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or	A 058		

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A 058	Continued From page 32 licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a	A 058		

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A 058	Continued From page 33 minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to document any known ˇ that a resident had in the Medication Observation Records (MORs) for one out of ten (#3) sampled residents. The facility failed to ensure that the medications had a scheduled time for four out of ten sampled residents (#3, #2, #6, and #10). The facility failed to keep centrally stored medications locked and out of reach of residents at all times. Because of this non-compliance the facility is required to employ the consultant services of a licensed pharmacist or a licensed registered nurse, who will, at a minimum, provide onsite quarterly consultation until an inspection by the Agency's personnel determines that such consultation services are no longer required. Findings included: On at 7:39 AM, there was a binder with sheets inside. The sheets were Medication Observation Records for Residents #2, #3, #6, #9 and #10.	A 058		

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A 058	Continued From page 34 Review of Resident #3's MORs showed that the box for identifying the resident's was blank. There was an order for applying 2% to the affected area daily as needed. The order started on and it was signed as given from thru , on , on and from thru . There was no documentation indicating the time or reason for the resident to receive the medication. There was an order for applying 20% to the affected area daily as needed starting on . The resident received the twice a day at "AM" and "PM" from to and there was no documentation indicating the time or reason for the resident to receive the medication. The resident's medications did not have a scheduled time; they just showed "AM" and "PM". Review of Resident #3's record showed that the facility identified in the demographic sheet. Review of Resident #2's MORs showed that the box for identifying the resident's was blank. There was an order for taking one tablet by twice a day of , 500 mg. The did not have a scheduled time; it just showed "AM" and "PM". Review of Resident #6's MORs showed that the medications did not have a scheduled time; they just showed "AM" and "PM". Review of Resident #10's MORs showed it included seven medication and none of them had a scheduled time; they just showed "AM" and "PM". The MOR did not show the route that the resident would receive the seven medications. The boxes for identifying the resident's	A 058		

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A 058	Continued From page 35 the resident's health care provider telephone number and the charting period for receiving medications were blank. On at 12:42 PM, the Administrator stated that the MORs for Residents #2, #3, and #6 came from the hospice pharmacy. On further interview at approximately 1:45 PM, the Administrator stated that she would fix the problems found on the MORs. On at 7:16 AM, there was a jar of with a label of Resident #2's name on the bedside table. On at 7:20 AM, there was an unlocked closet next to # . There was a medicated shampoo inside (labeled). On at 7:27 AM, there were an opened box in the refrigerator. There was an vial inside. There was a bottle of fish oil in one of the shelves inside the facility's refrigerator. There was a bottle of , on one of the shelves in the refrigerator. There were three small carton boxes in the refrigerator labeled with Residents #2, #3 and #6's names. They had medication inside. The facility's refrigerator was opened and remained open. On at 7:27 AM, Staff B stated that the belonged to Resident #10 who was at the hospital. Resident #10's nurse left the medication box opened. On /19 at 12:26 PM, the Administrator stated that the medication next to Resident #2's bed was used by hospice. On further interview at 12:27 PM, the Administrator added that the drops found in the refrigerator belonged Resident #2	A 058		

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A 058	Continued From page 36 and the medication over the counter belonged to the staff. On at 01:45 PM, Staff A acknowledged the deficiency. She stated that she stored the medications inside the refrigerator because the medications needed to stay refrigerated. Class III	A 058		
{A 077} SS=D	429.176 FS; 429.52( ),58A-5.019(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52( ), FS (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.	{A 077}		

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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
{A 077}	Continued From page 37 58A-5.019 Staffing Standards. (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and 4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before , are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule. 5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the	{A 077}		

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{A 077}	Continued From page 38 agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility.	{A 077}		

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{A 077}	Continued From page 39 (e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04002. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to be under supervision of an administrator who was responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents. The facility's Administrator supervised two Assisted Living Facilities (ALF). The facility appointed Staff F as the new Administrator who also supervised a second ALF. Findings included: Review of Florida Health Finder showed that the Administrator was responsible for supervise the facility. Review of Background Screening Database showed that the Administrator was responsible for supervise the facility. The database showed that the Administrator served as the Assistant Administrator to a second ALF. Review of Background Screening Database showed that the Administrator listed at the top of	{A 077}		

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{A 077}	Continued From page 40 the page with that position. The facility added as one of the employee with the position as Administrator to Staff F. Staff F's hire date showed " " and the facility added her to the roster on . . . . . The database showed that Staff F was the administrator for another ALF. The facility claimed that the Staff F started as the new Administrator on . On at 10:47 AM, the Administrator stated that she did not work at the second facility. The facility pointed Staff F as the new administrator since . . . . . The Administrator stated that Staff F administered the other facility which showed under Staff F's supervision. Uncorrected Class III	{A 077}		
{A 079} SS=D	58A-5.019(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 . . . 212 16- 25 253 26-35 294 36-45 335 46-55 375 56- 65 416 66-75 457 76-85 498 86-95 539 .	{A 079}		

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{A 079}	Continued From page 41 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 58A-5.024(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or [illegible] courses pursuant to subsection 58A-5.0191(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and [illegible]. 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be	{A 079}		

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{A 079}	Continued From page 42 physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the	{A 079}		

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{A 079}	Continued From page 43 requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.	{A 079}		

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{A 079}	Continued From page 44 (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 58A-5.029, 58A-5.030 or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have enough qualified staff to provide resident supervision and to provide resident services in accordance with the residents' scheduled and unscheduled service needs. Findings included: On at 7:10 AM, Staff B was at the facility taking care of three residents under hospice care and one day care participant. Two out of the three residents under hospice care (#2 and #3) were bed bound. A review of the staff pattern showed all days during the week were covered in 12 hours shift from 7 AM to 7 PM and from 7 PM to 7 AM with the exception of Tuesday. Staff pattern showed no staff on duty on Tuesday night from 7 PM to 7 AM. On at 1:09 PM, Staff B stated that she worked from 7 AM to 5 PM, and that the exit time could change to 7 PM. She further stated that she lived in the facility. She worked that schedule the majority of the time . A review of Resident #6's hospice record showed that the resident needed to reposition while on bed every two hours for preventing by relieving the pressure.	{A 079}		

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{A 079}	Continued From page 45 On at 1:13 PM, Staff B stated that she completed the First Aid and , , ( ) training. She remembered working with a doll. Someone needed when needs to be . She did not remember how to determine is a person needed a or the process (Steps) for completing a . She was never in that situation. She did not know how to do because she did not perform to anyone. On at 1:17 PM, the Administrator stated that the consisted of giving , , and breathing to an unresponsive resident that was not breathing and with no , . She would give 12 , and alternate with breathing. She would continue until the rescue arrive. Both Staff A and Staff B were unable to answer and demonstrate the knowledge of performing . A review of Residents #2, #3 and #6's records showed that they have the " ". A review of the participant record showed no documentation that the day care participant held a " ". On at 1:24 PM, the Administrator stated that she did not know that the daycare participant did not want to be . Uncorrected Class III	{A 079}		

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{A 081}	Continued From page 46	{A 081}		
{A 081} SS=D	58A-5.0191( ) FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this	{A 081}		

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{A 081}	Continued From page 47 requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies	{A 081}		

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{A 081}	Continued From page 48 and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a preservice orientation of at least 2 hours to one out of three sampled staff members (Staff B). Findings included: A review of Staff B's employee records revealed that the facility hired Staff B on . . . . . The facility did not have any documentation of a pre-service orientation in Staff B's record. On . . . . . at around 09:10 AM, Staff A stated that she thought she had the pre-service orientation for all the staff. Class III	{A 081}		
{A 093} SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the	{A 093}		

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{A 093}	Continued From page 49 National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1	{A 093}		

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{A 093}	Continued From page 50	{A 093}		

week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of [illegible] the time between meals.
(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents,

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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
{A 093}	Continued From page 51 including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow its menu. The facility also failed to have a substitute menu posted on the bulletin board. Findings included: On at 08:00 AM, observed Resident #6 sitting at the kitchen table while Staff B brought him his breakfast. The breakfast served was: coffee and milk, 4 sliced bread/toast and cheese, and a cup of water. On at 08:07 am, observed a posted menu on one of the facility's bulletin boards in a foreign language. The Facility Breakfast Menu for the day consisted of: Savory juices, ¾ cup dry cereal, 1 slice of bread, Margarine (butter), milk. On at 01:29 PM, Staff A acknowledged the breakfast menu was not followed. She stated that sometimes they made small changes on the menu.	{A 093}		

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	AL11966792	A. BUILDING: _____ B. WING _____	R 11/08/2019

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{A 093}	Continued From page 52 Class III	{A 093}		
{A 152} SS=D	58A-5.023(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 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	{A 152}		

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{A 152}	Continued From page 53 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 provide a safe living environment, free from unpleasant odor. Findings included: On at around 07:07 AM, Observation revealed a strong odor coming from the bathroom close to #. On at around 02:40 PM, Staff A acknowledged the deficiency. She stated the strong odor might come from the overnight diapers left in the bathroom or the from unflushed the toilet. Uncorrected Class III	{A 152}		
{A 160} SS=D	58A-5.024(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request.	{A 160}		

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{A 160}	Continued From page 54 (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 58A-5.025, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible]. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 58A-5.026, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 58A-5.021, F.A.C.; (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 58A-5.0181, F.A.C. (h) If the facility advertises that it provides special	{A 160}		

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{A 160}	Continued From page 55 care for persons with [redacted]'s [redacted] or related [redacted], a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (j) All food service records required in Rule 58A-5.020, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, observation and	{A 160}		

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{A 160}	Continued From page 56 interview, the facility failed to keep an up-to-date admission and discharge log. Findings included: Review of the admission and discharge log showed that Resident #7's admission date was on and the discharge date was . . . . . It did not indicate the reason for discharge or the place to which was discharge. There was a note next to the entrance showing "Day Care " and "End ". Resident #7's name was on an a different page of the admission and discharge log showing "Day Care"; it did not indicate when she started in the facility. On at 7:12 AM, Resident #7 was in the facility. She sat on the dining room. The resident wore a sleeping gown. On at 7:12 AM, Staff B revealed that Resident #7 was a day care participant; her daughter dropped her off around 6 AM. On at 9:36 AM, Staff A stated that Resident #7 stopped attending at the end of , . She came on . Review of admission and discharge log showed Resident #1's discharge date from the facility was on but it did not indicate the reason for discharge or the place where was discharged to. There was a note in the log indicating that the resident in a local hospital on . On at 9:25 AM, Staff A stated that Resident #1 had a (, ,) tube. She went to the hospital 10 to 15 days after the admission. The	{A 160}		

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{A 160}	Continued From page 57 hospital inserted that . . . . . during the hospitalization. The resident needed to go to the hospital after returning to the facility because she was sick. She at the hospital around seven to ten days later. Review of the admission and discharge log showed that Resident #4's discharge date was on . . . . . The note in the log showed that she went with her family. There was no documentation about the reason of discharge or the home address to which the resident was discharged. On . . . . . at 9:25 AM, Staff A stated that Resident #4's granddaughter decided to her home. Uncorrected Class III	{A 160}		
{A 162} SS=D	58A-5.024(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; 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	{A 162}		

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{A 162}	Continued From page 58 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 58A-5.0181, 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 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(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 58A-5.0181, 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 administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, 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	{A 162}		

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{A 162}	Continued From page 59	{A 162}		

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 [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible], CF-ES 1006, [illegible], 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 [illegible] 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 58A-5.0181, F.A.C.
(o) The resident's [illegible] DH Form 1896, if applicable.
(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;

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{A 162}	Continued From page 60 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, 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 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have accurate health assessment for three out of ten sampled residents (#2, #3, and #6). The three health assessment did not match with the type of help that residents received taking their medications. Resident #3's health assessment did not show the right [illegible]. Facility failed to have complete demographic data for one out of ten sampled residents (#10). Findings included: 1. On [illegible] at 7:16 AM, Residents #2 and #3 rested on their beds with full side rails up in Room	{A 162}		

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{A 162}	Continued From page 61 #1. Review of Resident #2's record showed that Resident #2 needed assistance with self-administration of medication according to the health assessment completed on . On at 8:49 AM, the MPT from hospice administered medications to Resident #2. She took out a tablet of , from the medication card, crushed it and mixed it with applesauce. The MPT put the mixed of the crushed medication with the applesauce in a spoon and placed it inside Resident #2's . A review of Resident #3's health assessment completed on showed that the resident was not bedridden. A review of Resident #6's record revealed that health assessment completed on did not include the medical diagnoses which caused him the admission to hospice. The medical diagnoses listed were: , ( ), ( ), HLP ( ), 2 (type 2), DOA ( ) and . A review of Resident #6's hospice Record showed that the diagnoses included , episodes, and . A review of Resident #10's record showed that there was a health assessment that missed the date of examination. 2. A review of of Resident #10's record showed that his admission date was on . The demographic sheet missed the name, address,	{A 162}		

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{A 162}	Continued From page 62 and telephone number of his health care provider. Class III	{A 162}		
{A 165} SS=D	429.23(&) FS; 58A-5.0241 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	{A 165}		

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{A 165}	Continued From page 63 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, 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.	{A 165}		

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{A 165}	Continued From page 64 (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 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, the facility failed to submit a complete adverse incident report within 15 days of the incidents to the Agency for Healthcare Administration (AHCA) for one out of ten sampled residents (#4). Resident # 4 at the facility, suffered a left , and was transferred to a higher level of care.	{A 165}		

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	AL11966792	A. BUILDING: _____ B. WING _____	R 11/08/2019

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{A 165}	Continued From page 65 Findings included: Review of the online state's Adverse Incident Reporting System (AIRS) revealed the facility filed an initial incident report on . . . . . in reference to Resident #4's that resulted in a . . . . . There was no documentation of the required follow-up report within 15 days. On at 3:15 PM, the Administrator stated that the facility's consultant was in charge of filing the adverse incident report. Uncorrected Class III	{A 165}		
{A 200} SS=D	58A-5.036 FAC Emergency Environmental Control (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 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	{A 200}		

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{A 200}	Continued From page 66 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 58A-5.026(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 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	{A 200}		

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{A 200}	Continued From page 67 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 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	{A 200}		

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{A 200}	Continued From page 68 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 rule. Assisted living facility plans previously submitted and approved pursuant to Emergency Rule 58AER17-1, F.A.C., will require resubmission only if changes are made to the plan.	{A 200}		

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{A 200}	Continued From page 69 (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 local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN.	{A 200}		

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{A 200}	Continued From page 70 (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 subsection (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 paragraph (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 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	{A 200}		

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{A 200}	Continued From page 71 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 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	{A 200}		

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{A 200}	Continued From page 72 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, Part I, F.S., or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines.	{A 200}		

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{A 200}	Continued From page 73 (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 observation, and interview the facility failed to maintain a minimum of 48 hours-worth of fuel onsite to ensure that it could maintain room temperature at or below 81 degrees in the event of a loss of primary power.	{A 200}		

Agency for Health Care Administration

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{A 200}	Continued From page 74 Finding Included: On . . . . . at 11:11 AM, observed 2 five-gallon (10 Gal.) containers of gasoline stored in a shed in the backyard. On . . . . . at 01:35 PM, Staff A stated that she did not know if she needed that much fuel. She thought that 10 gallons of gasoline were enough. Uncorrected Class III	{A 200}		